			1 - For State Registrar	State of Mary		artment of H			iene	11.	20501
	Physici		Decedent's Name (First, Middle, Last)     Thomas Edv	ward	Rhodes			2. Date of Dea Month	th Day	Year	3. Time of Death 1:30P M
>	/Medic Examir		4a. Facility Name (If not institution, give s Frederick Memoria	treet and number)	1410405	4b. City, Town, o		August	4c. County Freder	of Death	
	Funeral Director		5. Social Security Number 6. Sex  115-01-2797  Usual Residence of Decedent	M 2□F	yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days					lace (State or Foreign try) York
	iter death with the Maryland r Items 23a or 28a-f show	Funeral Director	10a. State 10b. County  Maryland Montgome  10e. Street and Number  5421 Amberwood Lan	ery	c. City, Town or Lo  Rockvil  in U.S. 13. v	Le 10f. Zip Code 20853	ispanic Origin? (	Specify Yes or No-			an Indian,
9500-61212	be filed within 72 hours after ital Hygiene. Id other than "neturel", or Ite other, the Medical Exar, it is	Completed by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	1 X Yes 2 □ No If Yes, Give WW Year or Dates:	VII	lent's Usual Occup	Specify: ation during most of w			Whi	te
<u> </u>	should be filed wond Mental Hygier marked other the market other the matic event, the matic	To Be Cor	12 17. Father's Name (First, Middle, Last) George Rhodes			ctrician	Mary	ame (First, Middle, I Monaghar	Maiden Sumam 1		
ore, mar	l and 2 steath ar trau		19a. Informant's Name/Relationship (Type Thomas R. Rhodes/ 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Re	Son 2	5421 Ob. Place of Dispos	Amberwood	d Lane,	Rural Route Number Rockville  Date Lember 3		0853	,
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		`4 □Donation 5 □Other (Specify)  21. Signature of Puneral Service License	J. Cole	Cemete	ery Name and Addres Incis J.	ss of Facility Collins	Funeral id, W, Sil	Home In	c.	MD 20901
	cate be executed /Medical Examiner the prival-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Resolution as a co	death. Do not enter  CM FC  nsequence of):  nsequence of):						Approximate Interval Between Onset and Death
BOX 6	It the death certificate by the attending physiached for use as the	Physiclan/Medle	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	ac. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	y Day Year
s, T	w requires that been signed by should be deta	by	Part II. Other significant conditions cont	tributing to death but no	t resulting in the un	derlying cause give	en in Part I.		acco use contr		e cause of deat
I	The law ate has b page 2 sl	Completed	My (notrition	^				24a. Was ar autops perform	ned? d	Vere autoprior to comeath?	sy findings available pletion of cause of
	or Attending Physicien: The standard of the clast. Director: After this certificate in by the funeral director, pag	ertification; To Be	25. Was case referred to medical examiner?  1	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - building, etc. (S)	At home, farm, stre	28c. Injury Work	er: 4 ☐ Nursing i	eath (Check only one Home 5 Reside 28d. Describe ho 28f. Location (Str City or Town	nce 6 Otherwinjury occurre	ed	
_	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Exemination	ician: To the best of my er: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at the timestigation, in my op	e, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) and mar ite and place, a	nner as sta nd due to t	ted. the cause(s)
	41	M	29b. Signature and title of certifier  JULICO CO  30. Name and address of person who con	C	(Item 23a) (Type. F		61117		Od. Date signed	4.0	
100	Sta Registr	A 50		32. Ragistrar's S	In Fre	South	MA	2 70			_

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2 **Physician** 2004 9:35 Μ. Ridgway September Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 X F Months Days Hours Min. 80 Director 220-12-3837 5, 1923 Washington, DC Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location rel', or Items 23e or 28e-1 show Examinar must be notified at 10d. Inside City Limits Derwood Maryland Montgomery 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 19120 Muncaster Road United States 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 Z No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 XWidowed 4 □ Divorced Specify: White "neturel", Year or Dates Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the M Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F Teresa Moore Hans Maurer ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tre once. Jean Chornock / Daughter 65 Bralan Court Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 2004 Silver Spring, MD 22. Name and Address of Facility  $\ \ DeVol\ \ Funeral\ \ Home$ Funeral Service License 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-tran c. Urose sis Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12-months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b 24a. Was an autonsy certificate 1 Yes 2□ No 2X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29b. Signature and title of certifier Tot 29c. License number 29d. Date signed (Month, Day, Year) D0061302 September 2, 2004 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road Atul Rohatgi, M.D. Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 3 2004 Registra

9:35 Am

9/2/04

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		1 - For State Registrar	State of Maryl		artment of H			iene <sub>eg. N</sub> o.	29503
Physici /Medic		Decedent's Name (First, Middle, Las	Janice L.	Rose			2. Date of Deat Month August		3. Time of Death 4 10:30 A
Examin		4a. Facility Name (If not institution, give 7206 Bells Mill	Road		Bethes			4c. County of Montgot	Death
Funeral Director		5. Social Security Number 6. Se 505–18–1902 Usual Residence of Decedent	7. Age (In)	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year)	Birthplace (State or Fore Country) Nebraska
ene. than "naturel", or iteme 23a or 28e-f show he Medical Examinar must be notified at	ctor	10a. State 10b. County	gomery 10c.	. City, Town or Lo		Bethesda			10d. Inside City Lim 1 ☐ Yes 2 📉
3a or 28 st be no	al Director	10e. Street and Number 7206 Bells	Mill Road		10f. Zip Code	20817	16	og. Citizen of Wha	ed States
ital Hygiene. d other than "naturel", or iteme 23a or 28e-f show event, The Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
ene. than "nature the Medical E	Completed	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most of wor	rking	16b. Kind of Busin	,
al Hygie d other event, L	Be Co	17. Father's Name (First, Middle, Last)	-		Homen		ne (First, Middle, M		n Home
	၉	Mill  19a. Informant's Name/Relationship (T)	s Lauderbacl		ng Address (Street a	and Number or Ri		y Oberly	
fealth ar		Bowen Rose, Jr./ S	Son	1070	O Greene	Drive Lo	orton, Vi		2079
Department of Himportent: If ite any injury or of once.		1  Burial 2  Cremation 3  ☐ 4  ☐ Donation 5  ☐ Other (Specify, 21. Signature of Foheral Service Licens	N	lational	Cemetery  Name and Addres	31,	2004 ert A. P	umphrev	e, Virginia Funeral Hom
4 5 6 6		23a. Part1. Enter the disease or comp shock, or heart failure. List only o	fications that caused the dine cause on each line.	leath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	01 wis	Approximate Interval Between Onset and Deat
ohysician and the burial-transit	dical Examiner	Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)	sequence of):	alnutr	itim			mart
he attending I led for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
been signed by t should be detach	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.			te to the cause of death?  Probably 4 □Unkno
page 2	Completed						24a. Was an autopsy perform	prior	e autopsy findings availa to completion of cause h? Yes 2 \(\sum \text{No}\)
his certifi il director	ıtlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of	28c. Injury Work	or: 4 ☐ Nursing He	th (Check only one ome 5X Resider 28d. Describe how	nce 6 Other (	Specify)
i hours after death uneral Director: oly filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	at home, farm, streecify)	eet, factory, office	-	28f. Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
Funer Funer ely fill	edical	29a. Certifier 1 X Certifying Phy (Check only one) 1 Medical Exami	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the cau	use(s) and manne te and place, and	r as stated. due to the cause(s)
/	M	29b. Signature and title of certifier	Weehl	calord	29c. License	number 00019785	29	d. Date signed <i>(M</i> August	onth, Day, Year) 25, 2004
>		30. Name and address of person who ca	ampleted seven of databall	Man 00-) (T					

Physician (Medical Examiner   As Paulity Name (if not institution, give street and number)   4a. Facility Name (if not institution, give street and number)   4a. Facility Name (if not institution)			For State Registrer	State of Maryla	and / Depa		Health and		9	20501.
Agent 25, 2004 1823  Fairmord  Director  Tournal  Director  Tournal  Director  Tournal  Tourn	Physici	an		•						3. Time of Death
1.8801   Kernelland Circle   2.15-04-0032   1.0 M 20%   2.1 m 20	/Medi	cal				4h City Tourn	or Location of De			
South Security Numbers   South Security Numb	Examir	ier		,				atn		
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The State of State and Number of Processing State of Stat	Director		213-04-0032	JM 2[XF 2	21 Yrs.	Months Days	Hours Mi	May 22,	1983 Ma	aryland
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Exemplay   College   Col	or 28	)ire	10e. Street and Number					10	0g. Citizen of Wha	t Country?
Exemplay   College   Col	ath w s 23e	ral							nited St	ates
Exemplay   College   Col	items items	une		Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origin? can, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		
Exemplay   College   Col	urs af	by		If Yes, Give		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
Exemplay   College   Col	72 ho	ted			16a. Dece	dent's Usual Occu	pation			
Source   S	ithin Ben "	nple			life.	DO NOT use retire	ed)	rorking		
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Ray L. Russo/Father    Committee   Committ	d be findal Head of	Be		·					faiden Sumame)	
Ray L. Russo/Father    Committee   Committ	should nd Me mark matic	۲		vpe. Print)	19b Mailir	nn Address (Stree			City or Town Star	to Zin Code)
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23a. Part I. Eiter the disease, or complications that observed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate flating in death)  But in flated expending in death)  FFEMALE:  23b. Was decedent pregnant in time of death in the past 12 months?  But immediate Cause (Pinal Rev. List only one cause on asethine mediate)  But in flated expending in death)  But in flated expending in death)  But in flated expending in death in the past 12 months?  But in flated expending in death in the past 12 months?  But in flated expending in death in the past 12 months?  But in flated expending in death in the past 12 months?  But in flated expending in death in the past 12 months?  But in flated expending in death in the past 12 months?  But in flated expending in death in the past 12 months?  But in flated expending in death in the past 12 months?  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying cause given in Part I.  But in flated expending in the underlying	rmit. ppartn porte y inju		21. Sign Tyre of it neral Service Lice of	66	22	2. Name and Addr	ess of Facility T	Robert A	Pumphrev	Funeral Hom
Approximate shorts of health cleases, or complications that cabled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate shorts of health fluid in the price of the cause of	89 5 8 9		1.3 Line	èu. MC	00803 RC	ckville,	Inc. Marylar	300 West M nd 20850-	ontgomer 2805	y Avenue
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Ves 2 Month   Day   Ves 2   Month   Day   Date	/Medical Examiner	Ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Find a Underty to Cause (Disease or injury that initiated events	Due to (or as a const	equence of):  Lon of H equence of):	lelium				Oriset and Death
Depression  Bulimia  24a. Was a great performed?   Depression   1   Yes 2   No 3   Probably 4   Unk   Depression   2   Yes 2   No 3   Probably 4   Unk   Depression   2   Yes 2   No 3   Probably 4   Unk   Depression   2   Yes 2   No 3   Probably 4   Unk   Depression   2   Yes 2   No 3   Probably 4   Unk   Depression   2   Yes 2   No 3   Probably 4   Unk   Depression   2   Yes 2   No 3   Probably 4   Unk   Depression   2   Yes 2   No 3   Probably 4   Unk   Depression   2   Yes 2   No 3   Probably 4   Unk   Depres	death certifi e attending ed for use as		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	etal death 3		:y			
25. Was case reterred to medical examiner?    To be a construct of the complete of the complet	quires tha in signed uld be det	by		ntributing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.			
25. Was case reterred to medical examiner?    To be a construct of the complete of the complet	aw re	plet	Bulimia							autopsy findings available
26. Place of Death (Check only one)  27. Manner of Death 1 Natural 28. Depth of place of Death (Check only one)  28. Depth of place of Death (Death one)  28. Depth of place of Death one)  28. Depth of place of Death (Dea	The late ha	E O						perform	ed? death	1?
1   Natural   1   Natural   2   Accident   3   Suicide   4   Homicide   2   Accident   3   Suicide   4   Homicide   2   Accident   3   Suicide   4   Homicide   4   Homicide   2   Accident   3   Suicide   4   Homicide   4   Homici	sien: artifica ctor.	ø					26. Place of Dr			
1   Natural   1   Natural   2   Accident   3   Suicide   4   Homicide   1   Natural   2   Accident   3   Suicide   4   Homicide   1   Natural   2   Accident   3   Suicide   4   Homicide   1   Natural   2   No   Name and address of person who completed cause of death (Item 23a) (Type, Print)   Carl I. Margolis, M.D., DME, 11125 Rockville Pike, Rockville, Maryland 20852	hysic his ce Il dire	ို	1X Yes 2□No	I □ Inpatient 2	☐ ER/Outpatien	t 3 DOA	her: 4 Nursing	Home 5 X Resider	nce 6 Other (S	(pecify)
building, etc. (Specify)  Home  City or Town, State) 14801 Keeneland City Gaithersburg, Maryland 208  14 Floridae  Page 15 15 16 16 16 16 16 16 16 16 16 16 16 16 16	ling F	on:	1 ☐ Natural 5 ☐ Pending	(Month, Day Year)	Approx	Wo	rk?	Put bag	winjury occurred filled wi	ith Helium
building, etc. (Specify)  Home  City or Town, State) 14801 Keeneland City Gaithersburg, Maryland 208  14 Floridae  Page 15 15 16 16 16 16 16 16 16 16 16 16 16 16 16	death ctor: y the	Icat	3 X Suicide 6 ☐ Could not be		+ 1/30	- 1	laes SXINO	over hea	d.	
29a. Certiflier (Check only one)  29b. Signature and ditle of certiflier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Carl I. Margolis, M.D., DME, 11125 Rockville Pike, Rockville, Maryland 20852	P # # =	ertii	4 Homicide determined	building, etc. (Spec	cify)	eet, lactory, office				
D15236 August 25, 2004  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Carl I. Margolis, M.D., DME, 11125 Rockville Pike, Rockville, Maryland 20852	a Hospita 24 hours Funeral etely filled		(Check only 2 Medical Exemi	ner: On the basis of examin	nowledge, death	occurred at the ti restigation, in my	me, date and place	e and due to the car	(so(s) and manner	as stated
D15236  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Carl I. Margolis, M.D., DME, 11125 Rockville Pike, Rockville, Maryland 20852	rothin omple	Me		· A A = 27		29c. Licen:	se number	29	d. Date signed (Mo	onth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Carl I. Margolis, M.D., DME, 11125 Rockville Pike, Rockville, Maryland 20852			· ~~~			D150	226			
Carl I. Margolis, M.D., DME, 11125 Rockville Pike, Rockville, Maryland 20852	1		30. Name and address of person who co	empleted cause of death (It	em 23a) (Type.		.36	A	ugust 25	, 2004
				•		,	Pike. R	ockville	Maruland	20852
Registrar SEP 02 2004 Server & Sports			31. Date filed (Month, Day, Year)	32. Registrar's Sigi	nature			VIIIE	riar A Tail(	20032

**Physician** 

**Funeral** 

Director

r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

e filed within 72 hours after of Hygiane.
other than "naturel", or item

12 should be fi and Mental H Is marked of

permit. Pages 1 and 2 st Department of Health and Important: if Item 27 Is rr any Injury or other traum

Physician /Medical

3altimore, Maryland 21215-0020

death with the Maryland

/Medical

Examiner 5. Social Security Number 578-38-8310 Usual Residence of Decedent 10a. State Director 10e. Street and Number Funerai 11. Marital Status ۾ Completed Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Harry Lee Rust, Jr. 19a. Informant's Name/Relationship (Type, Print) Catherine J. Rust/Wife 20a. Method of Disposition 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fulfure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Completed 25. Was case referred to medical Be Certification: To 27. Menner of Death 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 August 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra, MD., 7710 Bradley Blvd., Bethesda, Maryland 20817 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State 3 0 2004 Registrar AUG

**DHMH 16 Rev 6/95** 

	•	For State of Market State   St		artment of Health and rtificate of Death		eg. Ñd. 🗍 🗍 📗	29506
Physicia /Medic	ın	1. Decedent's Name (First, Middle, Last)  Helen F. Ryan			2. Date of Death Month August 3	Day Year	3. Time of Death 6:57 A. M
Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  Suburban Hospital  5. Social Security Number 6. Sex 1 □ M 2 ☑ F  Usual Residence of Decedent	e (In yrs. last birthday 74 Yrs.	Ab. City, Town, or Location of Deat  Bethesda  If Under 1 Year If Under 24 Hrs  Months Days Hours Min.	8. Date of Birth	rear) Cou	
Maryland	ctor	10a. State 10b. County  Maryland Montgomery	10c. City, Town or L			10 m	10d. Inside City Limits 1 ☐ Yes 2X No
th with the 23a or 286 Ist be not	Funeral Director	10e. Street and Number 10817 Old Coach Road		10f. Zip Code 20854		Og. Citizen of What Cou United Stat	·
72 hours after death with the Maryland netural; or Items 23e or 28e-f show alcal Exact or must be netified at	Ď	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces  1 Yes, Give X Year or Dates:		Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: Whi	e, etc.
rithin 72 ho ne. hen "netur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Given life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	Self-Empl	Loyed
d be filed w ental Hygier ced other th c event. II.	To Be Cor	17. Father's Name (First, Middle, Last)  George Unsinn	Musi		me (First, Middle, M		nce
12 shoul and Mari	F	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or R.	ural Route Number,	, City or Town, State, Z	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Importent: If them 27 is marked other then "netural; or items 23a or 28e-f show any injury of other treumetic event. It a Medical Examinating the notified at once.		James V. Ryan/Husband  20a. Method of Disposition  1 □ Burial 2 X Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licencee	20b. Place of Disp cemetery, cre Montgome Cremato		Date 2, 104 I	20c. Location · City or T Bethesda, M	Town, State Iaryland
Certificate be executed for including physician and formal transit including the burial-transit formal form	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events	d the death. Do not er ine. tion Pneum a consequence of): ary Hypert a consequence of):	nter the mode of dying, such as cardia			Approximate Interval Between Onset and Death
death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year
signed be de	by	Part II. Other significant conditions contributing to death	out not resulting in the	underlying cause given in Part I.		pacco use contribute to es 2 □ No 3 □ Pro	
The law ate has b page 2 sl	Completed					y prior to c ned? death? 2⊠No 1 □ Yes	topsy findings available completion of cause of
.is ya	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpat	ent 2 ☐ ER/Outpatio	Other	ath (Check only one Home 5 ☐ Reside	<i>e)</i> ence 6 □Other ( <i>Spec</i>	cify)
or Attending tter death. birector; Atter n by the fune	Certification:	27. Manner of Death  1 🛣 Natural  2 □ Accident  3 □ Suicide  4 □ Homicide  28a. Date of Inj (Month, Di (Month, Di ) 28b. Place of In building, e	ury Year) 28b. Time Injury  jury - At home, farm, s	Work? M 1 ☐ Yes 2 ☐ No		ow injury occurred  reet and Number or Rule, 5, State)	ral Route Number,
To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical C	29a. Certifier (Check only one)  1  Certifying Physician: To the besis and manner s	of examination and/or i				
To th To th comp	Me	29b. Signature and title of certifier  30. Name and address of person who completed cause of				August 31,	2004
Sta Regist		31. Date filed (Month, Day, Year) 32. Regist	ledical Cer	Sparks	ile, Mary	yiand 20050	

			For State Registrar	State of Maryland		tment of H		Aental Hygiene Reg. พื่อ	200	20507
	Physici	an	1. Decedent's Name (First, Middle, Last)		Ric	10		2. Date of Death Month Da	y Year	3. Time of Death
	/Medic	al ·	4a. Facility Name (If not institution, give:	street and number)			Location of Death	August 1	County of Death	0132 M
	LXdilli	CI		Cins Hospita	(	0 11	ore C	ity	,	
	Funeral Director		5. Social Security Number 6. Security Number 1	7. Age (In yrs. la:		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	l Cou	place (State or Foreign intry)
			Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loca	ation		5-1-200	7	
	death with the Maryland ms 23a or 28a-f show froust be notified at	tor	MD Kent			Hown				10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a	Director	10e. Street and Number	Cite	. 3101	10f. Zip Code		10g. Cit	tizen of What Cou	intry?
	s 23a	ral	209 EDMORE	Rd	40.141	2162			USA	1-1-1
(0	urs after death with el', or Items 23a or Examiner must be	Funeral	11. Marital Status 1 XNever Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No	lf '	Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
Maryland 21215-0036	be filed within 72 ho Ital Hygiene. Id other then "natur event, It e Modical	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		Yes 21X No	Specify:		Specify: W	hite
215-		Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give k	int's Usual Occupa ind of work done o O NOT use retired	during most of work	sing 16b. K	(ind of Business/l	ndustry
212		Com	0	3511095 (1-401-54)		Newbo				
land		To Be	17. Father's Name (First, Middle, Last)  Jame S	Rich				e (First, Middle, Maider Abeth	Leonais	o Rich
ary	and Maria maria	-	19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street a		al Route Number, City		
	s 1 and 2 should of Health and Men item 27 Is marke other traumatic		ELIZABETH /IN 20a. Method of Disposition	other-	209	EDMO(		Chestertou	ocation - City or 1	
Mor	Pages ent of I ot: If it		1 ☐ Burial 2 ★Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)		netery, cremi	tion (Name of atory or other place	e) 1	1 1	Ltinor	
Baltimore,	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Licens			Name and Address	1111		CTITIOT	O. INV
	<u> </u>		23a Part 1 Foter the disease or compl	cations that caused the death			Ife St		ve mo	Z1Z\$7 Approximate
	Physician	ć	23a. Part1. Enter the disease, or compl shock, or heart failers. List only of Immediate Cause (Final disease or condition	se cause on each line.		mata	Vitu	or roophatory arrest,		Interval Between Onset and Death
7	/Medical Examiner		resulting in death)	Due to (or as a conseque		rhoc. «	1 ( 9			Inour
		er	Sequentially list conditions, if any, leading to immediate	Due io (u. as a conseque	ence of):					
	executed in and ial-transit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
8760,	be icie	al Ex	resulting in death) Last	Due to (or as a conseque	ence of):					
9	tificate ng phys as the	Aedical	JEEGINIE .			anie-				
Вох	attending for use as	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand	death 3□E	ectopic pregnancy			23d. Date of delivership	very Day Year
Ö	t the de by the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□ Unknown	atn 5	Other (specify)				,
S, P	as the gned	by	Part II. Other significant conditions con	ntributing to death but not result	ting in the und	derlying cause give	en in Part I.			the cause of death?
Vital Records,	w require been sig should b	Completed				-				bably 4 Unknown
Rec	The lav	omp						24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
/ital	sicien: Th certificate irector, pag	BeC	25. Was case referred to medical examiner?			-		1 Yes 2 No	10163	20110
	Physi r this o	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death		R/Outpatient 28b. Time of	3□ DOA Cthe	4 🗀 Nuising n	ome 5 Residence 28d. Describe how inju		(fy)
lon	Attending Physicien: r death. sctor: After this certifice	atlon	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	28c. Injury Work	(? Yes 2 □No	Edd. Booding from High	ry occurred	
Division of	or Attendation after deat Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Street ar City or Town, State	nd Number or Rui e)	al Route Number,
	the Hospital nin 24 hours a the Funerel I		29a. Certifier 12 Certifying Phy	sician: To the best of my know	ledge, death	occurred at the tim	ne, date and place,	and due to the cause(s	) and manner as	stated.
	c the Hospital or Atten ithin 24 hours after deat or the Funeral Director: or pletely filled in by the	Medical	one)	ner: On the basis of examination and manner stated.	on and/or inve					
1	To the Youthin Societies	2	29b. Signature and title of certifier			29c. License			te signed (Month	
V	P.H.		30. Name and address of person who co	empleted cause of death (Item :	23a) (Type, P		25-00		). ,	2004
7	6/		AUCE COOPANG, M.D.	600 N W3	Ife S.	+ Phipps	5 279 8	allymore	MO Z	1287
	St: Regist	ate rar	31. Date filed (Month, Day Year) SEP 1 6 2	32. Redistrar's Signatu	St Ja	parte				

		AMEND FIFM #23a PF 1. Decedent's Name (First, Middle, Las	State of Marylan	id / Depa	rtment of H <i>tificate of</i>	lealth and <i>Death</i>		giene Reg. No:() ()	01	20500	
6 o	nysician	1. Decedent's Name (First, Middle, Las AIDA FLOR SAN		<del>.0/U4 J</del>	fi		2. Dete of Dee Month SEPT		Year 0 0 4	3. Time of Death	
	/Medical Examiner	4a Facility Neme (If not institution, give CIVISTA MEDIC.	street end number)			4b. City, Town, o	or Location of Death	4c. County	of Deeth		
	uneral rector	579-76-9967	Пм эГХ Е	lest birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 H	in. 8. Date of Birt	CHAR V, Year) 5,1932	9. Birthple Count	ece (Stete or Foreign ry) OMBIA	_
death with the Marylend	and show	Usuel Residence of Decedent  10a. Stete 10b. County  MARYLAND CHAR		y, Town or Loo					10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No	_
th with the	r items 23a or 28a-f s niner must be notified Funeral Director	10e. Street end Number 2221 NEWBURGH C	Т.		10f. Zip Code	602		10g. Citizen of \	What Count	ry?	
020 urs after dea	Ç A	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates:		Vas Decedent of I- Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	Blac	ce - America ck, White, e		
Maryland 21215-0020 td 2 should be filed within 72 hours aft th and Mantel Hygiena.	nt, the Medical in th	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occup kind of work done OO NOT use retire	during most of v d)		16b. Kind of B			
yland 2  yland be filad  Mantel Hygi	arked other atic event, I	17. Father's Neme (First, Middle, Last) ISIDURO JIMEN	EZ	NUR	SING AS	18. Mother's N	Iame <i>(First, Middl</i> e, ELA PERI			)ME	
ealth and	n 27 ia m her traum	19a. Informant's Name/Relationship (1)  LUIS A. SANCHEZ	- HUSBAND	2221	NEWBUR			RF, MD	2060	2	
Baltimore, Demit. Pages 1 a Department of Hea	ant: if Iter lury or oth	20a. Method of Disposition  1 □XBurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	emetery, crem	sition (Name of latory or other pla RS CHUR		9-10-04	20c. Location -		wn, State M.D	
Ball permit Depart	any in	21. Signature of Funeral Service Licen	M00479	1/1-	RAYMON	D FIME	RAL SEK	/ICE, 1	. A.		
/Me	sician edical miner	23a. Pant 1. Enter the disease, or compshock, or heart failure. List only of limited the cause (Final disease or condition resulting in death)	e. ASP TVB  Due to (c	_			ERMINAL)	rest,		Approximate Interval Between Onset and Death	
68760, fricete be executed	physician and s the buriel-trensit edicai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Jschen Due to (c		vence of):	DIS	cox.				_
₩ :=		resulting in death) Last	d	. 43 0 0013640	ionos orj.						_
I Records, P.O. Box The law requires thet tha death cert	been signed by the attending should be detached for use e leted by Physician/Mo	Part II. Other eignificent conditions co	ontributing to death but not res	ulting in the un	derlying cause giv	ven in Part I.				the cause of death?	_
Division of Vital Records, for Attending Physician: The law requires that death.	paga 2 should be d		, •				24a. Was perfo	an autopsy med?	avai	re autopsy findings ilable prior to spletion of cause eath?	
ital Fi	ertificeta l' ector, pagi Be Cor	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o		10	Yes 2□ No	_
n of Vita g Physician:	er this ce heral dire n: To	1 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Dey Year)	ER/Outpatient	3 □ DOA Oth	4 C Nursing	Home 5 Resid			1	-
Division or Attending after death.	To the Funeral Director: After this certificate has completely tiliad in by the funeral director, paga 2  Medical Certification: To Be Comp	1 SNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		Injury ome, farm, stre	\M 1□	Yes 2 No	28f. Location (S City or Tow	treet end Numb n, State)	er or Rural	Route Number,	_
Hospita 4 hours	he Funeral Detely fillad pletely fillad edical Ce	29a. Certifier 1 Certifying Phy (Check only one)	/siclan: To the best of my kno Iner: On the basis of examina and manner steted.	wledge, death tion end/or inv	occurred at the tire	me, date and pla ppinion, death oc	ce, and due to the c	ause(s) and ma	inner as sta and due to !	ited. the cause(s)	_
To the within 2	To the comple	29b. Signature and title of certifier	M. Tagae		29c. Licens D = 5 (	0883		Sept.	,		
_		30. Neme and address of person who of TAGOURI, YAHIA	completed cause of death (Item	23e) (Type, F POINT	rint) LOOKOU	JT ROAI	D LEONA	RDTOWN	MD	20650	-
2	State	31. Date filed (Month, Day, Year)	Registrer's Signa		1 . S. J.						-

			For State Registrar	State of M	laryland / De <sub>l</sub>	partment of H		•	giene Reg. Nő: () () [	
	0		Decedent's Name (First, Middle, Las	st)				2. Date of De	<del></del>	3. Time of Death
п	Physici		James Lee SMITH					Septem	per 06 200	4 5:36 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number	·)	4b. City, Town, o	r Location of De		4c. County of Dea	
	LAGITIT	C.	Washington Count	v Hospita	a 1	Hager	stown		Washing	ton
	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. last birthda		If Under 24 H	lrs. 8. Date of Bir (Month, Da		thplace (State or Foreign ountry)
ш	Director		220-02-8395	G <sub>X</sub> M 2□F	21 Yrs.	Months Days	Hours			aryland
	pu 🔪		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Logation				10d Ippide City Limite
	eho	5								10d. Inside City Limits 1 Yes 2 XNo
	he M	Director	Maryland Washin	igton	Smi	hsburg			10-02:	
	a or			ı		10f. Zip Code	-0-		10g. Citizen of What Co	ountry?
	eath	era	13001A Rowe Road	12. Was Deceden	t Ever in U.S. 1:	3. Was Decedent of H	783	(Specify Yes or No	USA - 14. Race - Ame	erican Indian
	fter d	Funerai	1 ★ Never Married 2 Married	Armed Forces	1?	If Yes, specify Cuba	an, Mexican, Pu	ierto Rican, etc.)	Black, Whi	
ğ	urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	i	1 ☐ Yes 2 ☑ No	Specify:		Specify:	white
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or Hems 23a or 28a-f ehow ont, the Me Heal Ever in minst be coefficed and	Completed	15. Decedent's Ed		16a. De	cedent's Usual Occup	ation	undking	16b. Kind of Business	/Industry
2	thin 7	npie	(Specify only highest gra	College (1-4o	(5+)	. DO NOT use retired	d)	HUKING		
2	ed wi	S	12	0	1.6	wn care			non pro	fit
Maryland	tal H d oth	Be	17. Father's Name (First, Middle, Last) Harold Lee Smith					Name (First, Middle		
<u>Ş</u>	ould I Men varke	은						thy Ann K		
<u>a</u>	12 st h and 7 tan traun	1 8	19a. Informant's Name/Relationship (						er, City or Town, State, Md. 21783	Zip Code)
	1 and Heall em 2		20a. Method of Disposition	moener	20b. Place of Dis	position (Name of		Date	20c. Location - City or	Town, State
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Ever minet be rediffied any injury or other traumatic event, the Medical Ever minet be rediffied any injury or other traumatic event, the Medical Ever minet be rediffied.		1 ₺ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specification 1)		e cemetery, c	rematory or other plac Lawn Mem. P		/9/04		
Baltimore,	artme ortan injur		21. Signature of Funeral Service Licer		Gedal .	22. Name and Addre			Hagerstown FUNERAL HO	
B	Dep Imp		I Tred LV	estal	٠.		•		stown, Mary	
			23a. Part1. Enter the disease, or com	plications that cause	ed the death. Do not e					Approximate
	Physician	5	shock, or heart failure. List only Immediate Cause (Final	one cause on each	Tre Carles	F. b. 1107	520			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or a	is a consequence of):	1100/1/61	10-1			1 hour
h	Examiner		One of the first and divine	b. =						
	D 5	ner	Sequentially list conditions, if any, leading to immediate		s a consequence of):					
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90,	icate be executed physician and s the burial-transit	Õ	resulting in death) Last	Due to (or a	s a consequence of):					
8760,	cate b	dicai		_ d.						
9	ding p	0	IF FEMALE:	23c. If yes, outcom	e of pregnancy					
Вох	attene for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	B Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
o.	the de	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown		Other (specify)				
<u>a</u>	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	y P	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
rds	quires n sign	d by	Neurfibr noto	5/5				1 🗆	Yes 2₽No 3□P	robably 4 Unknown
00	w requir s been si should	Completed	mitsel velve	000/00	50.			24a. Was	an 24b. Were a	utopsy findings available
ä	The tav te has age 2	mo	mintil cuta	11.100					rmed? death?	completion of cause of
Vital Records,	ysician: The list certificate hadirector, page	Be C	25. Was case referred to medical	11/10/1	-		26. Place of I	1 ☐ Yes Death (Check only o		2 110
>	iysici iis cel direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Inpa	tient 2 ER/Outpat	ient 3 DOA Oth	or		dence 6 □Other (Spe	icify)
n of	ding Ph h. After th funeral		27. Manner of Death  ∫ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b. Time Day Year) Injur		y at k?	28d. Describe	how injury occurred	
Sio	endir eath. or: Al	catic	2 ☐ Accident investigation	n			Yes 2 □ No			
Division	or Att	Certification;	3 Suicide 6 Could not b 4 Homicide determined	200. Flace 01 I	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location ( City or To:	Street and Number or R wn, State)	ural Route Number,
	urs al		20 0 17 170 170							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, t	edical	29a. Certifier   Certifying Ph (Check only 2 Medical Exar	niner: On the basis and manner:	of examination and/or	am occurred at the tir investigation, in my o	me, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	omple	Me	29b. Signature and title of certifier			29c. Licens	a number		29d. Date signed (Mont	h, Day, Year)
-	r > F 0		And the second s	The second secon	m	0-0	0564	113	9/7/00	115P
	2		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)	Mary		// / - 7	1 ' "
9	b**		Lis S. Sater	EL 5	0 1 1	Dr. W	Mam	sport "	11 21795	,— 
	Sta		31. Date filed (Month, Day, Year) SEP 0 8 2	32. Regis	strar's Signature	/				
	Regist	ar	JEF VO Z	UU4 /	and M.	land the				

Sinith, James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_1	State Registrar		Cei	tificate of L	Death		Reg. No	29510
Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Ye	
/Medic	al -	Clifford 1	erry	Shark			Septemb		
Examine	er	<ol> <li>Facility Name (If not institution, give s</li> </ol>	street and frumber)		4b. City, Town, or			4c. County of E	Death
		5. Social Security Number 6. Sex	Courty 7 Ann	(In yrs. last birthday)	Il Under 1 Year	Under 24 Hr	's. 8. Date of Bir	rth 9.	Birthplace (State or Foreign
Funeral Director		220-09-7577 X	(M 2□F	89 Yrs.	Months Days	Hours Mir	April 2	22,1915	Mary I and
and	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
death with the Maryland ms 23s or 28s-1 show	tor	Maryland Washing	aton		Willi	amsport			1 ☐ Yes ZMNo
th the	lred	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	
ath wi	rai	15639 Clear Spri				21795			ISA
er de	Funeral Director	TT: Warter Otatas	12. Was Decedent Ev Armed Forces?	1044-	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? ( in, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		American Indian, Vhite, etc.
Z I Z I D=UUSO  within 72 hours after death with the Marylan jiene. r than "natural", or items 23s or 28s-f show the Medical Examment in collines at	þ	1 Never Married Married 3 Widowed 4 Divorced	1 □Yes 2 □ No If Yes, Give Year or Dates:	,	1□ Yes 2□XNo	Specify:		Specify:	White
72 h	etec	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of w	rorking	16b. Kind of Busin	ess/Industry
within the control of	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	) life.	00 NOT use retired Laborer	,		Leather	Processing
E E E	e Co	17. Father's Name (First, Middle, Last)			Labor Ci		ame (First, Middle	, Maiden Sumame)	
a g a b e	To B	John H. Shank				Esther	Do	wney	
arylar should be and Menta le marked aumatic e	-	19a. Informant's Name/Relationship (Ty	pe, Print)		-			er, City or Town, Sta	
127 E 2		Irene M. Shank -	Wife	A COLUMN TO THE REAL PROPERTY AND ADDRESS OF THE PARTY AND ADDRESS OF T		pring R			Maryland 21795
Ore,		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ R	temoval from State	20b. Place of Dispo cemetery, cres	sition (Name of matory or other plac	ce)	Date	20c. Location - City	y or Town, State
altimor		* 4 Donation 5 □ Other (Specify)	121-						ort,Maryland
Baltimol permit. Pages Department of Important: If is any niury or one		21. Sign ture of Juneral School cens		ð 4	sborne fu 25 S. Con	iherali H locochea	ome, P.A gue St.	Williamspo	21795 ort,Maryland
		23a. Part 1. Enter the diffease, or complishock, or heart failure. List only or	ications that caused t	he death. Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	M	wo and,	4 7	staret.	20		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					100%
LABITIME	-	Sequentially list conditions,	0.	consequence of):	ne Cere	Loursen	to Di	Seese	- Car
nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 10 (0) 23 2	consequence ory.					
Records, P.O. Box 68/60,  The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit.	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
68760 ificate be e g physiciar as the buri			d						
rtifica	Medical	IF FEMALE:							
BOX auth cer attendir for use	No.	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 ☐ Live birth 2	Petal death 3 □	Ectopic pregnancy	,		23d. Date of Month	I delivery Day Year
he de	Physician	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime ol death 5[	Other (specify)				
15, P.O. res that the de signed by the a	/ Ph	Part II. Other significant conditions co	ntributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
Records, he law requires t a has been signe ge 2 should be o	d by						1 🗆	Yes 2□No 3	Frobably 4 □Unknown
Cord w require s been si	olete						24a. Was		e autopsy findings available
II Rec	Completed						auto perf	ormed? deal	r to completion of cause of th? Yes 2□ No
	BeC	25. Was case referred to medical				26. Place of D	eath (Check only		
	To	examiner?		t DER/Outpatie		4 🗀 Nursing		idence 6 Other (	Specify)
ing P	inol	27. Manner of Death  SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	k?	28d. Describe	how injury occurred	
VISION Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injur	ry - At home, larm, st		Yes 2 □No	28f Location	(Street and Number of	or Rural Route Number,
Division of all or Attending Physics after death. It Director: After this od in by the funeral d	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	leet, lactory, office			own, State)	ir narai noate Namber,
Division ( To the Hospital or Attending Faithin 24 hours after death.  To the Funeral Director: After completely filled in by the funer.	Medical (		sician: To the best of iner: On the basis of and manner stat	examination and/or in					
within To th compl	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (A	fonth, Day, Year)
		1/2/tom	m.D.		200	060057		9/3/04	1
M		30. Name and address of person who co					1		
Th.		31 Data liled (Month Day Year)		r's Signatura	bed .	Stree	+ Ha	moterne	MO 21748
Sta Registr		SEP 0 7 2	004 32. Habistra	r's Signature	lad.				
T C C I S I	aı_			Market Die	DEME				

		-	For State Registrar	State of Ma	•	partment of <i>ertificate o</i>		nd Mental I	Hygiene Reg. No	nni	29511
	Physici /Medic		1. Decedent's Name (First, Middle, Last) $Ruth  B \   .$	Spencer				2. Date o Month Augu		Year 2004	3. Time of Death  1:01 A
7	Examin		4a. Facility Name (If not institution, give s Laurel Regional			4b. City, Town	, or Location of ${ t rel}$	Death		County of Death	
	Funeral Director		5. Social Security Number 6. Sex 578-64-8547	7. Ag M 2⊠F	90 Yrs	Months Day		Min. (Month		9. Birthi	place (State or Foreign htry) ington DC
	he Maryland	Director	Usual Residence of Decedent	ery	10c. City, Town o	Location  Liver Spri			10g Citiz	zen of What Cou	10d. Inside City Limits 11⊠ Yes 2 □ No
	h with t	al Dir	1900 Lyttonsville	Road #60	07	209			Tog. Onla	U.S.A.	-
036	be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "naturel", or Items 23e or 28e-f ehow other than "naturel", or Items 20e or 28e-f ehow event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		I3. Was Decedent of If Yes, specify Control of Image 1		in? (Specify Yes o Puerto Rican, etc.	.)	14. Race - Ameri Black, White, Specify:	
Maryland 21215-0036	within 72 ho ine. Iban "natur ie Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			ecedent's Usual Occ live kind of work dor e. DO NOT use ret Educat	ne during most ired)	of working		nd of Business/In	•
7	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other ti any injury or other fraumatic event, In once.	Be Co	17. Father's Name (First, Middle, Last)	<u></u>				's Name (First, Mi			:MC
ylan	should be nd Mental marked c	ToB	Unobtainable					Julia Br			
Mar	d 2 sh th and th and traum		19a. Informant's Name/Relationship (Ty)  Judy E. Spencer-			ailing Address <i>(Stre</i> 400 Queen					Code) 2 MD 20782
re,	is 1 and of Health Item 27 other to		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other p	-	Date	1	cation - City or To	
Baltimore,	Pages ment of tant: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)		1	ncoln Cre	matory			ntwood,	
Bail	permit. Depart Import any inj		21. Signature of Funeral Service License	96		22. Name and Add		Fort Lin g Road			
8760,	death certificate be executed  Examine and continued and control a	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as Due to (or as	ne.	rive	lying, such as c	ardiac or respirato	ny arrest,		Approximate Interval Between Onset and Death
O. Box 6	death certifi e attending id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregnal 5 ☐ Other (specify)			_ 2	3d. Date of deliv Month	ery Day Year
rds, P.	sign d be		Part II. Other significant conditions cor	ntributing to death b	ut not resulting in the	ne underlying cause	given in Part I.			•	he cause of death? pably 4 Unknown
Reco		Completed							Was an autopsy performed?	24b. Were auto prior to co death? 1  Yes	opsy findings available mpletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital: , क			Othor	of Death (Check o		- Wine	
Division of Vital Records,	spital or Attending Physicus after death. Instal Director: After this filled in by the funeral di	ertification; To	1 ☐ Yes 2 ♣ No	1 A Inpation 1 A I	ry 28b. Tin	ne of 28c. Ir	4 🗆 1401		ribe how injury		у)
Divis	al or Atte s after de il Directo	Certific	3 Suicide 6 Could not be determined	28e. Place of In building, et	ury - At home, farm c. <i>(Specify)</i>	, street, factory, office	Ce Ce		on (Street and r Town, State)		al Route Number,
	Hos 24 h Fur stely	edical (	29a. Certifier 1  Certifying Phy (Check only one) 2  Medical Exami		f examination and/						
)	To the within 2 To the complet	¥	29b. Signature and title of certifier	Tale	lmare	29c. Lice	D 2534	8	1	e signed (Month, August 3	•
C	R (3)		30. Name and address of person who co			ype, Print) y Grove F	oad Da	ockwill o	MD		
	St Regist	ate rar	Maria Goldmark 31. Date filed (Month, Day, Year) SEP 0 3 2004		ar's Signature	oly Glove F	wau K	DCKATITE	בוח		
Di	MH 17 Rev 1/2	2001				-					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Year **Physician** 8:15 A M Sarah Jean Sweitzer 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL Cumberland Allegany HEART SACRED If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Min 1□ M 2 F 212-80-7262 89 Director October 28, 1914 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Maryland Allegany Lonaconing 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 16101 Old Beechwood Road S.W. 21539 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3. Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If Item 27 is marked other than "n any injury or other traumatic evant, the Medions. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Steele Lacey Durst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Bittinger-Daughter 19804 Woodland Road, Frostburg, Maryland, 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State September Davis Memorial Cemetery 4 □ Donation 5 □ Other (Specify) 14, 2004 Cumberland, Maryland 22. Name and Address of Facility. Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street 21. Signature of Funeral Service Licensee 116/ Lonaconing, MD 21539 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shopk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HCUTE Inferror Wall
Due to (or as a consequence of): My lander Infarction **Physician** DAYS disease or condition resulting in death) /Medical **Examiner** ARTER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SHOCK CARdigenio 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed OF RECENT CORENARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 Yes 2 No 1 🗌 Yes 2 🗌 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Vinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 2 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified September 12, 725638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANG M.D 10701 New Heory Creeks & & Frostong Mary Land SATURNINA 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 2004 Registrar

			1 _ State	State of Maryland / Depa	artment of Health and M rtificate of Death			20110
			Registrar  1. Decedent's Name (First, Middle, Last)		Timeate of Death	2. Date of Death	g. No.	3. Time of Death
	Physicia	an		_		Month	Day Yeer	14
	/Medic	al	Edwin Lowe Sare  4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death	Sept.	7 2004 4c. County of Death	0025am
	Examin							
		9	Memorial Hospi 5. Social Security Number 6. Sex	tal 7. Age (In yrs. last birthday)	Easton If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Talbot 9. Birthpla	ace (State or Foreign
	Funeral Director		100	M 2□ F 92 Yrs.	Months Days Hours Min.	June 1		MD
			Usual Residence of Decedent					
	yian how		10a. State 10b. County	10c. City, Town or Lo	ocation		10	d. Inside City Limits
	e-f s	cto	MD Caro	line	Preston			1 ☐ Yes 2/XNo
	or 28	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Count	y?
	23a	al	22799 Marsh C		21655		USA	
	r dea	Funeral	11. Walter Status	Armed Forces?	Was Decedent of Hispanic Origin? (Sp tf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: Wh	ite
Ö	ural'	d b	3 Widowed 4 Divorced	Year or Dates:	dent's Usuat Occupation	11	6b. Kind of Business/Indu	
<u>5</u>	"nal	Completed	15. Decedent's Educa (Specify only highest grade of	completed) (Give	kind of work done during most of work DO NOT use retired)	ing	ob. Kind of basinessind	zstry
12	withi ene. than	mc	Elementary/Secondary (0-12) 8 t h	College (1-4or 5+)	iry and Grain F	0 10 m 0 10	Agricultu:	ro
0	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28e-f show ant, the Medical Examinat must be notified at		17. Father's Name (First, Middle, Last)			e (First, Middle, M		
<u>la</u> n	td be ental ked o	To Be	Ernest L Sard		Anni	e Skipp	er Sard	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked othar than "natural; or Itams 23a or 28e-f show any injury or other traumetic avant. The Medical Examinal must be notified at ance.	1-	19a. Informant's Name/Relationship (Type	e, Print) 19b. Maili	ng Address (Street and Number or Rur			Code)
	nd 2 Ilth a 27 is r trau		Rosealie L Saro	1 22	799 Marsh Creek	Pd Dr	eston MD :	21655
altimore,	s 1 a f Hea ftam othe	1	20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)		0c. Location - City or Tow	n, State
9	Page ent o nt: If ry or	li	1, Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	moval from State		1/04	Easton Ml	v.
#	mit. F sartm oortal inju		21. Signature of Funeral Service Licensee		2. Name and Address of Facility	1704	Easton M	J
m	permi Depar Impo any ir		> Muchael 7/2	Kow	Framptom's 216	N. Mai	n St Fed.	MD 21632
	20		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death. Do not en			st .	Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition		lial Infarction			Onset and Death
7	/Medical		resulting in death)	Due to (or as a consequence of):	ilai illaiction			
	Examiner		Sequentially list conditions b.	Urosensis			S24-14	
		Jer	if any leading to immediate	Due to (or as a consequence of):				
	cuted nd ransii	Examin	Cause. Enter Underlying Cause (Disease or injury that initiated events  c.					
ó	exe an ar urial-t		resulting in death) Last	Due to (or as a consequence of):				
8760,	cate be executed obysician and the burial-transit	dical	d.					
9		Med	IF FEMALE:		7.0			
Вох	death certifics e attending pl ed for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of deliver Month	y Day Year
		Sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 5 [ 9 ☐ Unknown	Other (specify)			,
P.0	that the de led by the a detached f	Phy	Part II. Other significant conditions conti	ributing to death but not regulting in the .	undorkving cause given in Part I	23a Did toba	acco use contribute to the	cause of death?
	Se De G	by	Part II. Other significant conditions conti	induling to death out not resulting in the d	andenying cause given in Fatti.	1 ☐ Yes		bly 4 □Unknown
orc	w requir been si should	ted						
Records,	taw tas b	ple				24a. Was an autopsy	prior to com	sy findings available pletion of cause of
		Completed				perform 1 ☐ Yes 2	ed? death?	No
Vital	iclan: certific rector,	Be	25. Was case referred to medical examiner?			h (Check only one	)	
of \	Physiclan: this certific ral director,	၉	T Tes 2 TNO	Ospital: 1 Inpatient 2 ER/Outpatie			nce 6 Other (Specify)	
u u		on:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe hov	w infury occurred	
Sio	Attanding or death. actor: Affel by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	206 Leasting /Ctm	and and blombar or Doml	Courte Alive has
Division	l or Attand after death Diractor: , I in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	City or Town,	eet and Number or Rural State)	Houle Number,
	urs a		Co. C. Iff	inian. To the best of my knowledge dee	the construction of the co	and due to the sec	uso(a) and manner or ste	tod
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical		ician: To the best of my knowledge, deat er: On the basis of examination and/or in and manner stated.				
	To the within 2 To tha complet	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29	d. Date signed (Month, D	Pay, Year)
	F \$ F 8		100 72	7.00	D0059487		9/07/04	
			30. Name an odress of person who con	noleted cause of death (Item 22a) (Trees			2,01,04	
				) MHE 219 S Wash		on Md 21	1601	
	St	ate	31. Date filed (Month, Day, Year)	20 Defeated Cignoture		- 11 11	2001	
	Regist		SEP 0 9 20		A sept a			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3 Time of Death . Decedent's Name (First, Middle, Last) Month Day Year **Physician** August 28, Helen Yvonne 2004 Satterfield 0120 - /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □X 72 577-44-3190 Mar 19, 1932 Director Washington, DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. Count 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 TYes 2 □ No Directo Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a or 10201 Brink Road 20876 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Item any injury or other treumatic event, the Medical Exemptons. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 **Black** If Yes, Give Year or Dates: Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Social Worker Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Satterfield Willodene Graves 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorie Ann Satterfield Thomas 10201 Brink Road Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 09/02/2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 22. Name and Address of Facility
McGuire Funeral Service, I
7400 Georgia Avenue, N.W. 21. Signature of Funeral Service Cidense Hanna 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1.006 CANCER **Physician** MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 2X No To the Hospital or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No 18 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Cartifier Medicai within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MARYUND AUGUST 28,4004 D42452 30. Name and address of a son who completed cause of death (Item 23a) (Type, Print) DK RAJAGOPAL CHIMA 20832 PHILIP DRIVE #347 18/11, PRINCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State pered 03 2004 SEP Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Yeer ochonberger G 30AM 2004 /Medical 4a. Facility Name (If not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Monta Cross Vex JOY INCL If Under 24 Hrs omeru If Under 1 Year 8. Date of Birth (Month, Day, July 20 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) Czechoslovakia **Funeral** Days 192<u>2</u> 217-72-2405 1 XM 2 ☐ F 82 Hours Director JulyUsual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic event, the Mudical Examiner must be notified at Md Montgomery Silver Spring 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Иете 23в 1121 University Blvd. West # 506 20902 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: if Item 27 Is marked other then "natural", or Ite 1 ☐ Never Married 2 X Married 1 ☐ Yes Z\ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Baker Ottenberg Bakeries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Schonberger Frida Moshkovitz ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benjamin Ilkovitch, son-in-law 10502 Tuckerman Heights Circle, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State Ø \* 4 □Donation 5 □ Other (Specify) Mt. Lebanon Cemetery Sept.3,2004 Adelphi, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc 201 254 Carroll St., NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ancer year 5 una /Medical resulting in death) Due to (or as a consequence of): Examiner OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed DIEZUTE and attending physician a I for use as the burial-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has irector, page 2 s autopsy performed 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 3 Duicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) physician anni AH2328195RN34 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) University 32. Registrar's Signature State 03 SER 2004 Registrar

1.   Cooleder's Name (First, Middle), Last)   Edward   Vincent   Sheal   County			FOL	artment of Health and Mental Hy <i>rtificate of Death</i>	rgiene Rag. NQLO OL. OOF LC		
Examiner  4.5 - Facility Name (if not institution, give street and number) Doctors Community (Hospital)  5. Social Security Number  5. Social Security Number  6. Sim  7. Age (in yrs. last brinday)  10. Sites (10. Sites)  10. Site		an		Month	path Day Year 3. Time of Death		
Doctors Community Hospital    Fine   Prince George   Prince   Prince George			4a. Facility Name (If not institution, give street and number)				
Director Dir			Doctors Community Hospital	Lanham	Prince George's		
Do. Sister and Number   TAUGH   Thince George's   Too. City, Town or Location   Too. State and Number   TAUGH   Too. Street   TAUGH   Too. Street   TAUGH   Too. Street   TAUGH   Too. Street   Too. St			233-46-2442 1½ M 2□F 71 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Bit Months   Days   Hours   Min.   May 2,	orth (2) 9. Birthplace (State or Foreign Country) West Virginia		
Elementary/Secondary (0-12) College (1-4or 5+)  Accountant  Public Utility  17. Father's Name (First, Middle, Last)  James Vincent Shea  19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code)  Micheline M. Shea/ Wife  20a. Mithod of Disposition  15c Burial 2 Coremation 3 Chemostry (1709, Print)  15c Burial 2 Chemostry (1709, Print)  15c Burial 2 Chemostry (1709, Print)  15c Burial 2 Coremation (1709, Print)  15c Burial 2 Chemostry (1709, Print)  15c	and *	}		ocation	10d. Inside City Limits		
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Elementary/Secondary (0-12)   College (1-4or 5+)   Accountant   Public Utility	28a-	Je C			10g. Citizen of What Country?		
Elementary/Secondary (0.12)   College (1.4or 5+)   Accountant   Public Utility	3a or		7406 Allison Street	20784			
Elementary/Secondary (0-12)   College (1-4or 5+)   Accountant   Public Utility	deati	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No	14. Race - American Indian,		
Elementary/Secondary (0-12)  Elementary/Secondary (0-12)  College (1-4or 5+)  Accountant  Public Utility  18. Mother's Name (First, Middle, Maiden Surmame)  Mary Conrad  19a. Informant's Name(First, Middle, Last)  James Vincent Shea  19a. Informant's Name(First, Middle, Maiden Surmame)  Micheline M. Shea/ Wife  7406 Allison Street, Hyattsville, MD 20784  20a. Method of Disposition  19a. Business of Sheat Salve, Sal	ours after al', or Ite	þ	1 Never Married 2 Married 1 Married 2 Married 1 Married 2 Married 1 Married				
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Micheline M. Shea/ Wife  7406 Allison Street, Hyattsville, MD 20784  20a. Method of Disposition 12 Burial 2   Gramation 3   Ramoval from State 14   Donation 5   Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 22 Name and Address of Facility 23 Name and Address of Facility 24 Name and Address of Facility 25 Name and Address of Facility 26 Name and Address of Facility 27 Name and Address of Facility 28 Name and Address of Facility 29 Name and Address of Facility 29 Name and Address of Facility 20 Name and Address of Facility 20 Name and Address of Facility 20 Name and Address of Facility 25 Name and Address of Facility 26 Name and Address of Facility 27 Name and Address of Facility 28 Name and Address of Facility 29 Name and Address of Facility 29 Name and Address of Facility 20 Name and Address of Facility 21 Name and Address of Facility 22 Name and Address of Facility 23 Name and Address of Facility 24 Name and Address of Facility 25 Name and Address of Facility 26 Name and Address of Facility 27 Name and Address of Facility 28 Name and Address of Facility 29 Name and Address of Facility 29 Name and Address of Facility 29 Name and Address of Facility 20 Name and Address of Facility 25 Name and Address of Facility 26 Name and Address of Facility 27 Name and Address of Facility 28 Name and Address of Facility 29	i be findal H	0			, Malden Sumame)		
Micheline M. Shea/ Wife  7406 Allison Street, Hyattsville, MD 20784  20a. Method of Disposition  15 Burdal 2   Cremation 3   Removal from State  15 Burdal 2   Cremation 3   Removal from State  15 Burdal 2   Cremation 3   Removal from State  16 Burdal 2   Cremation 3   Removal from State  17 Burdal 2   Cremation 3   Removal from State  18 Burdal 2   Cremation 3   Removal from State  19 Burdal 2   Cremation 3   Removal from State  19 Burdal 2   Cremation 3   Removal from State  20 Burdal 2   Cremation 3   Removal from State  19 Burdal 2   Cremation 3   Removal from State  20 Burdal 2   Cremation 5   C	d Me d Me mark metic	F			or City or Town State Tip Code)		
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FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 3   Probably 4   Month Day Y	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):  C	AdenoCarcinoma	Thues weeks		
	t the death certificate be by the attending physici ached for use as the bu		23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No				
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		
D 48213 09-01-2004	0011		NUShou M.D	D 48213	09-01-2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NECKUL AShar 4410 74th Ave landover Hills MD 20784	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)						
State Registrar SEP 03 2004  32. Registrar's Signature  ### ### ### ### ####################	Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	/			

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_		Physici /Medic		BLAN		SHEINHOI	RN							Day 2004		9P M
		Examir			(If not institution, giv		ber)		4		r Location of Deal	h		4c. County of Death		
				5. Social Security I	IRBAN HOSI		Ann /In u	rs. last birth	day) I	BETHE Under 1 Year	SDA If Under 24 Hrs	Doto of 5	) int	MONTGOME		
		Funeral Director		074-42-7	531	1 □ M 2 🔀 F	. Age (III y	94 Yı	// N	lonths Days	Hours Min		Day Ye	ar) 9. Birth Col MASS.	place (State intry) ACHUSE	TTS
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36	Baltimore,	tment tent: If		` 4 ☐ Donation	Cremation 3 5 Other (Speci	fy)	JUI		1EMO	RIAL GA	RDEN 08	/31/04		DINEY, MAI	RYLAND	
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				23a. Part1. Enter shock, or he	the disease, or con art failure. List only	nplications that ca	used the de	eath. Do no							Approxima Interval Be	tween
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		/Medical Examiner		resulting in death,	(			sequence of	):							
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		ne death the atte	Physician/M	in the past 1: 1 \(\sum \) Yes 2	2 months?		th 2□F intattime c			topic pregnancy her (specify)	<u>′</u>			Month	-	Year
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8		To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)	Certifying P	hysician: To the l miner: On the ba and mann	sis of exam	knowledge, of ination and/	death od or invest	curred at the ting igation, in my o	ne, date and place pinion, death occu	e, and due to thurred at the time	e cause e, date a	(s) and manner as s and place, and due t	stated. o the cause(s	s)
		To th To th comp	Me	29b. Signature an	d title of certifier	0	4	14	2	29c. Licens			29d. [	Date signed (Month,		
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		,		30. Name and add	dress of person who	dompleted cause		tem 23a) (T	ype, Prir Rock	evine	PIKE,	RU MD	20	852		
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Physician / Medical Examiner    Medical Examiner	Balti	permit. Departn Importe any inju			3						) C 21	0012
Physician (Medical Examiner)  The property of condition and a consequence of the condition	1.1			23a. Part1. Enter the disease, or complications t	hat caused the death. Do	o not ente	er the mode of dyin	g, such as cardia	c or respiratory	ngton, Darrest,	IC 21	Approximate
FEMALE:  230. Was decodent pregnant in past 12 months of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1   Yes   2   Monorm   2   Fixed death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   1   Yes   2   Monorm   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   1   Yes   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   2   Month   2   Fixed death   3   Ectopic pregnancy   Month   Day   Year   2   Month   2   Month	18			Immediate Cause (Final disease or condition resulting in death)	ALZHEIN		ers Di	SEASE	<u> </u>			Onset and Death
Part	1697 160 1914				e to (or as a consequenc	e orj.						
Part		po is	iner	if any, leading to immediate cause. Enter Underlying	e to (or as a consequenc	e of):						
Section   Part		and and II-trans	хаш	that initiated events resulting in death) Last  Cause (Disease of Injury that initiated events  C.  Du	e to (or as a consequenc	e ol):						
FEMALE   23c.   If yes, outcome of pregnancy   1   Live bith   2   Fetal death   3   Ectopic pregnancy   3   Ectopic pregnancy   3   Ectopic pregnancy   3   Ectopic pregnancy   4   December   4   Dec	09/	sician buria	aiE									
The part of the pa	9		a)	- U								
The part of the pa	Ö	the death certy the attending the attending the attending to the attending the ached for use	nysician/M	23b. Was decedent pregnant in the past 12 months?	ive birth 2 ☐ Fetal dea PregnanI at time ol death							,
25. Was case referred to medical examiner?  1   Second		quires that n signed b ıld be deta	by	Part II. Dther significant conditions contributing	to death but not resulting	in the ur	nderlying cause give	en in Part I.				/
State   Stat	I Reco		Complete						auto perf	opsy formed?/	prior to cor death?	impletion of cause of
The state   The	/ita	cien:	Be	examiner?			0.4		ath (Check only	one)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WARRY N. ROSEN BAOM 3720 FARRAGUT AUE SIK'KENSINGTON M920891  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	of	Physic this cral dir		T Tes 2 10			1 3 DOA	4   Nursing	1			γ)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WARRY N. ROSENBAOM 3720 FARRAGUT AUE SIL'KENSINGTON M920891  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	5	ding th. : After	tion	1 → Hatural 5 ☐ Pending	Month, Day Year)				200. 200020	now injury coodi.		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WARRY N. ROSENBAOM 3720 FARRAGUT AUE SIL'KENSINGTON M920891  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Visi	Atter ector by the	iffica	3 Suicide 6 Could not be determined 28e. I		larm, stre	eet, lactory, office				er or Rura	l Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WARRY N. ROSENBAOM 3720 FARRAGUT AUE SIL'KENSINGTON M920891  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	Ö	rs afte	Cert	/	randing, etc. (Specify)				Only or 10			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WARRY N. ROSEN BAOM 3720 FARRAGUT AUE SIK'KENSINGTON M920891  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		n 24 hou he Funer	edical	(Check only 2 Medical Exeminer: On	he basis of examination	lge, death and/or inv	occurred at the tin restigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time	cause(s) and ma , date and place, a	nner as st and due to	tated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FARRY N. TOSEN FACM 3720 FARRAGUT AUE SIL'KENSINGTON M920891  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		To t To t	Σ	29b. Signature and title of certifier	1		29c. License	e number		29d. Date signed	1 (Month, I	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FARRY N. ROSENBAOM 3720 FARRAGUT AUE SIL'KENSINGTON M920891  State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		5		1 AR Kosept	reun		DO	9834		91110	7	
State Registrar  SEP 0.2. 2004  32. Registrar's Signature  Apauls	سنو			BARRY N. ROSENBA	OM 3726	a) (Type,	Print) ARRA6	UT AUE	sat'k	ENSIN	670.	NMD20891
					32. Registrar's Signature	B	Sporks	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 28, **Physician** 2004 Nancy P. Solo 10:05 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Hospice-Casey House Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept. | 28, 1932 7. Age (In yrs. last birthday). 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Liberia Director None Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28e-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3609 Pear Tree Court, #41 20906 Liberia filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Own Home marked other treumetic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other treumetic event sings. 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Pablomeh Margon T. Slewon 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3609 Pear Tree Court, #41, Silver Spring, MD 20906 Gabriel D. Nmah/ Son-in-law August 31, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven 1 Burial 2 □ Cremation 3 □ Removal from State 2004 Silver Spring, Maryland 0 ^ 4 □ Donation 5 □ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee Francis Collins Funeral Home Inc. AnneMariestucker 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and the for use as the burial-transit The law requires that the death certificate be executed C. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2□ No 1 Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 2 \square$  Other (Specify) Hospice 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending death. 1 Tyes 2 No investigation after death Director: 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 1XI Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division of Vital Records. P.O. Box 68760. or Attending Physicien: To the Hospitei within 24 hours a To the Funerel D

Baltimore, Maryland 21215-0036

Registrar

one

29b. Signature an

31. Date filed (Month, Day, Year) 3 1 2004 AUG

Joseph Kaplan, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title o

6001 Muncaster Mill Road, Rockville, MD 20855 32. Registrar's Signature

29c. License number

D35635

29d. Date signed (Month, Day, Year)

August 29, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Alfredo Alfonso Soto August 24 2004 8:00  $A^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1XM 2□ F Hours 79 Director 578-60-4076 14 Cuba Nov. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show many injury or other traumatic event, the Medical Examinar must be notified at once. 1 Yes 2 □ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Cilizen of What Country? 2 should be filed within 72 hours after death with is and Mental Hygiene. Is marked other than "naturat", or items 23a or 2 9 Chestnut Street 20877 United States Funerai 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes ≥ 2 ANo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: þ Cuban Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printer General Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leopold Soto Maria Pelaez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olga A. Soto / Wife 9 Chestnut Street Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 1 2 X Cremation 3 ☐ Removal from State Aug. 27, 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory Alexandria, Virginia 2004 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Boler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dead **Physician** Dorvei afudiones disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CEMTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed una/8 resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, oulcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte d be detached for Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown pinous Completed peen 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Phyaician: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 al or Attending F after death. I Director: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be determined Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerat Di cai 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INEZ, NO MARC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 0 2004 Registrar

			For State Registrar	State of M	laryland		artmeni rtificate					giene	004	2952	
			1. Decedent's Name (First, Middle, I	_ast)			·			:	2. Date of De	ath		3. Time of D	)eath
	Physicia /Medic		James L. Staf:	ford						I	August	26 ,	2004 Year	9:36	A M
	Examin		4a. Facility Name (If not institution, g						Location of	of Death		4c. (	County of De	ath	
			Montgomery Gener				0 If Under	lney		04 Nes 1			ntgome		
	Funeral Director		5. Social Security Number 6. 332-28-8442	. Sex 7. A 1 (X)M 2 □ F	ge (In yrs. Ii 68	ast birthday) Yrs.	Months	Days	If Under Hours	Min	3. Date of Bir (Month, Da June 2	th 1v. Year) 7 19	9. B	rthplace (State or . Country) CANSAS	Foreign
	P .		Usual Residence of Decedent		145 05										
	arylar ehow	<u>_</u>	10a. State 10b. County		1	, Town or Lo								10d. Inside City	
	28e-1	Director	Maryland Montgot  10e, Street and Number	nery	Silv	er Sp		0-4-				40 - 000			- 140
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	Jeeth ne 23	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S	S. 13.			ispanic Ori	gin? (Spec	ifv Yes or No			erican Indian,	
ထ	or Iter	ם	1 ☐ Never Married 2 X Married	Armed Forces	? INo 196	0-					ify Yes or No ican, etc.)	- 1	Black, Wh	ite, etc.	
8	be filed within 72 hours after deeth with the Maryland ital Hygiene d other then "naturel", or Iteme 23a or 28e-f ehow event, the Medical Examinat number collities at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	196	66	1 ☐ Yes	NO LJ	Specify:			A	Specify: Africar	n America	ın
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Maryland 21215-0036	lid be lental ked (	To Be	Thomas Stafford						Mry	tle V	Wheele:	r			
ary	s ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a					Town, State,	Zip Code)	
	es 1 and 2 should be fi of Health and Mental H if Item 27 is marked oth r other treumatic ever		Hildred Roach	(wife)							Lver S	pring	, MD	20905	
Baltimore,	T Sec 1	,	20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐Removal from State	20b. PI	ace of Dispo emetery, crea	natory or o	ne of ther plac	θ)	Da		20c. Loc	cation - City o	r Town, State	
Ë	t. Pag tmenl tent: tent:		*4 □ Donation 5 □ Other (Spe	cify)	Pa	rklaw			1	9/1/0			ville,		
Bal	permit. Pages 1 Depertment of H Importent: If Ite any njury or o once.		21. Signature of Funeral Service Lic	21. Signature of Funeral Service Licenstee  22. Name and Address of Facility  McGuire Funeral Service Licenstee  23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiace										a Ave. N D.C. 20	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that cause by one cause on each	d the death line.	. Do not ent	er the mod	e of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between	een
\ -	Physician	K H	Immediate Cause (Final disease or condition	Rup	tured	thora	cic a	orti	c ane	urysı	n			Onset and De	
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of):									1
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ć	death certificate be executed e attending physician and nd for use as the burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or a	s a consequ	ience of):									
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9	ntifica ng ph as th		IC CCMALC.												
Вох	leath certific attending p I for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			Ectopic pr	egnancy				2	3d. Date of de	,	
0.	at the dea by the at tached fo	Physician/Me	1 Yes 2 No	4☐Pregnant a 9☐Unknown	at time of de	eath 5	Other (sp	ecify)				ŀ	Month	Day Ye	ar
۵.	that the ed by detacl		Part II. Other significant conditions	s contributing to death	but not resu	ilting in the u	nderlying c	ause oiv	en in Part t		23e Did t	obacco us	se contribute	to the cause of dea	ath?
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202	> D 10	lete									24a. Was	20	24h Were	utopsy findings av	vailable
Vital Record	The law cate has b page 2 st	Completed									auto perfo	psy prmed?	prior to death?	completion of cau	ise of
tal	ilcien: Th certificate rector, pag	a	25. Was case referred to medical						26 Place	of Death /	1 ☐ Yes (Check only o	MO No	1 ☐ Ye	s 2X No	
Ž	y s	To B	examiner? 1 ☐ Yes 2 [X]No	Hospital: 1 ☐ Inpat	ient 2 <b>K</b>	ER/Outpatier	nt 3 🗆 DO	A Othe					Other (Spi	ecify)	
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D	jury ay Year)	28b. Time o	f 2	8c. Injury World			d. Describe				
Sio	Attending ir death. ector: After by the fune	catl	2 Accident investigat 3 Suicide 6 Could not				М	1 🗆	Yes 2	No					
Division	o it is	Certification:	4 Homicide determine	ed 286. Place of Ir	njury - At ho atc. (Specify	me, farm, str	eet, factory	, office		28	3f. Location ( City or To	Street and wn, State)	l Number or P	Rural Route Numbe	er,
J	spite ours inlec		29a. Certifier 1 Certifying	Physician: To the bes	t of my know	wledge deat	h occurred	at the tim	ne date an	d place an	nd due to the	Called(a)	and manager	s stated	
	To the Hos within 24 ho To the Fun completely	edical	(Check only 2 Medical Ex	caminer: On the basis and manner s	of examinat	ion and/or in	vestigation,	in my o	pinion, dea	th occurred	at the time,	date and	place, and du	e to the cause(s)	
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	00.	- D. Pl		29c	. License	number			29d. Date	signed (Mor	th, Day, Year)	
	10+1		I Jeffrey (	1 tal	CE_	W	) 1	D 47	188		A	Augus	t 27,	2004	
			30. Name and address of person with	no completed cause of	death (Item	23a) (Type,	Print)								
			Jeffrey A. Per				ontro	se R	oad,	Rocky	ville,	MD	20852		
	Sta Registi		31. Date filed (Month, Day, Year)  AUG 3 0 2	2004 32. Regis	trar's Signat	ure 5	pool	eks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Year **Physician** рм Margaret Mary Stanley 11:42 August 30, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Sunrise Assisted Living Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🙀 F Yrs Director 213-46-8702 96 Oct. 5, 1907 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other \*\*----10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits 1 ☐ Yes 3 ☐ No Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15101 Interlachen Drive, #704 20906 Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 1 ☐ Yes 2 ☑ No Specify: Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be J. ဂ္ William Carroll Margaret M. Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Stanley/ Son 10494 Graeloch Road, Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition 20c. Location - City or Town, State September 3 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 Cemetery 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 1 run Van 1/4/cm 500 University Blvd. w., Silver Spring, MD 20901 23a Part 1. Enter the dilease, or simplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart from the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebrovascular Accident 2 months disease or condition resulting in death) /Medical Examiner Arteriosclerotic Cerebrovascular Disease 2 Months Sequentially list conditions, in any, loading to immediate cause. Enter Underlying Cause (Disease or riplury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown s been signed by should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed Coronary Heart Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 1□ Yes 20 No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1 ving Assisted Hospital: Certification: To 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Facility After 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Box 68760 P.O. Division of Vital Records, Physician: Hospital or Attending Diractor: filled in by hin 24 hours a To the within ? To tha

State

Medical

31. Date filed (Month, Day, Year) 03 2004 Registrar SEP

29b. Signature and title of certifier

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi, M.D. 3305 N. Leisure World Blvd., Silver Spring, MD 20901 32. Registrar's Signature

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oaks

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D24543

29d. Date signed (Month, Day, Year)

September 2, 2004

12

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) JANGARE 04:10 AM **Physician** SIAKAM ASMINE 09 04 04 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL ROCKVILLE SHADY ADVENTIST MONTGOMERY GROVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 D NONE MARYLAND Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f show the Medical Examiner must be notified at 1 Des 2 No ROCKVILLE MARYLAND MONTGOMERY Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 ROAD #21 USA "natural", or Items 23a 718 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2☐No 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) INFAN permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other i any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be KANGA- WOUAFO ELVIRE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD #21, KANGA-WOUAFO/MOTHER 718 CLOPPER GAITHERSBURG, MO ELVIRE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BALTIMORE MARYLAND CYCLE 10-04-04 TERI <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility once 901 MEDICAL CENTER DRIVE, ROCKVILLEMS Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prematuri **Physician** Severe disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** horioamn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No should be detached the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? 2 🗆 No 1 TYes 2 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 1 10 2 ER/Outpatient 3□ DOA Certification; To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury or Attending 5 Pending investigation 1 Watural 1 Yes 2 No hours after death. uneral Director: A 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours at To the Funeral D To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 14118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER DRIVE, SHADY GROVE ADVENTIST MB LEE, DOROTHY 1 6 State Registrar

		1 - For State Registrar	State of M	Marylar			nt of Hea te of De		Mental Hy	giene	2001	20521
		Decedent's Name (First, Middle)	Last)		-				2. Date of De	ath		3. Time of Death
Phys	ician dical	WILLIAM GRAF	TON THOMP	SON					SEPT.	Day 7	, 2004	8:10 P <sup>M</sup>
	niner	4a. Facility Name (If not institution,	give street and numbe	r)		4b. City	, Town, or Los	cation of Dea	th		County of Death	
		13465 ROCK P	OINT ROAD	)		NE	EWBURG	3			CHARLE	S
Funer	al	5. Social Security Number		Age (In yrs.	last birthday)	If Unde Months		Under 24 Hrs		h v. Year)	9. Birth	place (State or Foreign
Directo	or	577-14-5531	XIXM 2□ F	85	Yrs.	I I I I I I I I I I I I I I I I I I I	July		APRIL			ASH.,DC
pu &		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation						10d Incide City Limits
vith the Marylan or 28a-f show	5	Tou. State										10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M 28a-f	Director	MARYLAND C  10e. Street and Number	HARLES		NEWBU		p Code			10- 00		
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hours after death with the Maryland turel; or Items 23s or 28s-f show	Funeral	13465 ROCK PO	12. Was Deceden	t Ever in II	S 13 1	Was Door	206		Consider Voca or No		U . S . 14. Race - Ameri	
ter de	Ë	1 Never Married 2 X Marrie	Armed Forces	3? 7 No.				Mexican, Puer	Specify Yes or No rto Rican, etc.)		Black, White	
irs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:1941	-1945	1 🗆 Yes	<b>≱</b> ∑Mo 5	Specify:			Specify: TAT L	ITE
2 hou		15. Decedent	s Education		16a. Deced	dent's Usu	al Occupation	n		16b. Ki	nd of Business/Ir	
d within 72 h piene. r than "natu	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5 £ ± \	(Give	kind of wo DO NOT o	ork done durir ise retired)	ng most of wo	orking			,
d with	E	10	College (1-40)	1 J+)	ELEC	TRIC	TAN			PF	EPCO	
be filed within 72 tal Hygiene. d other then "naile	Be	17. Father's Name (First, Middle, L	ast)					. Mother's Na	me (First, Middle,			
	10	WILLIAM AUGUS	TUS THOMP	SON			Е	BESSIE	E MAY V	ANGE	EUDER	
d 2 should be filed within the and Mental Hygiene. 7 Is marked other than treumatic event, ItaM.		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	ng Addres	s (Street and	Number or R	ural Route Numbe	r, City o	r Town, State, Zij	Code)
permit. Pages 1 and 2 Department of Health a Important: If item 27 is		MARJORIE THOM	PSON - WI	FE	1346	5 RC	CK PI	RD.,	P.O.BO	x 10	)1,NEWB	URG,MD206
of He		20a. Method of Disposition  2 Disposition	2 (18	1 -	Place of Dispo	sition (Na	me of	1	Date		cation - City or To	
Pages nent of int: If it		`4 □Donation 5 □Other (Sp		$ \mid$ $ \mid$ FT		-	CEM.	9-1	5-04	BRE	ENTWOOD	, MD
permit. Departn Imports any inju	ej O	21. Signature of Funeral Service L	icensee MO	0479			nd Address of					,
8855	a	Mulm	60.K		1	RAYM	OND F	UNERA	L SERVI	ICE,		
100		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that a use	ed the deat	h. Do n	er the mo	de of dying, su	uch as cardia	c or respiratory ar	2964 rest,	0	Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition	. Met					Can				Onset and Death
/Medica		resulting in death)	Due to (or a				17	4/11	. ~ /			
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a conseq	uence of):				, , , , , , , , , , , , , , , , , , , ,	-		
cuted	Examiner	Cause (Disease or injury that initiated events	с									
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or a	s a conseq	uence of):							
ate be hysicia the bur	dlcal	1	d									
leath certifica attending ph	Med	IF FEMALE:										
ith ce tendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	e of pregna 2 Feta	ancy Ideath 3	Ectopic p	regnancy			2	3d. Date of delive	,
ne dea the at	scl	1 ☐ Yes 2 ☐ No	4□Pregnant a			Other (s					Month	Day Year
at the de 1 by the etached	Phy	9 Unknown										
es that igned I be det	b	Part II. Other significant condition	is contributing to death	but not res	ulting in the ur	nderlying o	ause given in	Part I.				ne cause of death?
w requir been si should	ted						<del> </del>		1 U Y	es 2[	No 3 ☐ Prob	uably 4 Unknown
law re as be	Completed								24a. Was a	an	24b. Were auto	psy findings available mpletion of cause of
	νo								perfor	med? 2 X No	death?	2 No
ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					26.	. Place of Dea	ath (Check only or	70)		
Attending Physician: If death.  Ctor: After this certific by the funeral director,	2	1 ☐ Yes 2 No	Hospital: 1 Inpat		ER/Outpatien	t 3□ D0	OA Other: 4	↓ Nursing H	lome 5 Resid	ence 6	Other (Specify	y)
ng P fter t	in o	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inj (Month, D.	ury a <i>y Year)</i>	28b. Time of Injury	2	28c. Injury at Work?		28d. Describe h	ow injury	occurred	
endi eath. or: A	catl	2 Accident investig	ation			М	1 🗆 Yes	2 🗆 No				
or Att after d Direct in by	Certification	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of in	njury - At ho etc. <i>(Specif</i> )	ome, farm, stre	et, factor	y, office		28f. Location (S City or Tow	treet and n, State)	Number or Rura	l Route Number,
ital o												
Hospital 24 hours a Funeral I	edical	29a. Certifier Certifying	Physician: To the besi xaminer: On the basis	t of my kno of examina	wledge, death	occurred	at the time, d	ate and place	and due to the course of	ause(s)	and manner as st	ated.
the the	led	Uney	and manner s	tated.								
Vith Conf	Σ	29b. Signature and title of certifier	11			-	c. License nur		2	9d. Date	signed (Month,	Day, Year)
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		1100	no completed cause of	death (Item	23a) (Type, F						/	
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Regi	State strar	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	W						

			For State Registrar	State of Ma	arylan	-	artment of I			•	giene Reg. No. [	101.	20525
			Decedent's Name (First, Middle, Last	)						2. Date of De	ath	<del></del>	3. Time of Death
	Physici		RAY MONS	FRA	الم	<11-	THO	MPS	500	Month 5	Day	Year Zoou	17=11 M
	/Medio Examin		4a. Facility Name (If not institution, give				4b. City, Town, o				4c. Coi	unty of Death	
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	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. I	ast birthday)	If Under 1 Year Months Days		24 Hrs. 8	Date of Birt	th		place (State or Foreign
	Director		243-18-4726	XM 2□ F	92	Yrs.	Months Days	riours	1	1 / 8 / T	, , , , ,	Vir	ğınia
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c Cib	, Town or Lo	antion						Od Ionida City Limita
	aryla shov	_	MD Harford				cation						0d. Inside City Limits 1 ☐ Yes 2 No
	Ne M	Director			ADE	erdeen	10f. Zip Code				10- 011	-614//	
	with t		10e. Street and Number 301 Irish Lane					001				of What Coun	iuy?
	s 23	Funeral		12. Was Decedent	Syor in 11	S 12 1	210		igin? (Speci	ty Vac or No		.S.A. Race - Americ	nan Indian
	ter de Itam	Ę.	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces?		J. 13.	Was Decedent of I f Yes, specify Cub	an, Mexicar	n, Puerto Ri	can, etc.)	14.	Black, White,	
38	Irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes XXNo	Specify:			Spe	ecity: Whit	te
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show thet, I'ra Medical Examirat must be notified at	ted	15. Decedent's Edu	cation		16a. Deced	ient's Usual Occu	pation			16b. Kind o	of Business/Ind	dustry
37	Media 7	ple	(Specify only highest grad	e completed) College (1-4or 5	i+\	life. I	kind of work done OO NOT use retire	d)	it of working	'			
2	filed within Hygiene. other than ant, I'm Me	Completed	12	O O		Civi.	L Service	€			U.S.	Governm	ment
5		Be	17. Father's Name (First, Middle, Last)							First, Middle,	Maiden Sur	name)	
/lai		10	Franklin Thomp	son				l N	Mary P	erry			
Maryland 2	s man		19a. Informant's Name/Relationship (T)			,	g Address (Street				. ,		Code)
	1 and 2 Health tam 27 i		Eva M. Thompson (	Spouse)	,	and the second second second	Irish La	ne, A		-			
Baltimore,	9		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Pi	ace of Dispo emetery, cren	sition (Name of natory or other pla	· 1	Dai		20c. Location	on - City or To	wn, State
Ĕ	Pages nent of B ant: If its ury or of		'4 □Donation 5 □ Other (Specify)		Har		1em. Gdns	,	/4/04			een, MD	)
alt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	99	1	22	Name and Addre Carring—C Aberdeen,	ss of Facilit	ty Funer	al Hom	p D 7	λ	
<u> </u>	89689		Kusten Hou	sunge	espe	2 1	berdeen,	Mary	land	21001	-3359	7.	
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	cations that deused ne cause on each lin	the death	. Do not ent	er the mode of dyi	ng, such as	cardiac or i	espiratory ar	rest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		+ A	SCJ	·> .						Onset and Death
1	/Medical		resulting in death)	Due to (or as									
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	ecute and trans	Examine	that initiated events resulting in death) Last	c			-						
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		roodking in doubly 2250	Due to (or as	a consequ	ience or);							
87	cate b	dical		d							<u>-</u>		
9 x	leath certifica attending pl	Physician/Me	IF FEMALE:	22a If yes outcome	of proons	201							
Box	ath c	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Fetal	death 3	Ectopic pregnanc	<i>y</i>			23d.	Date of delive Month	ry Day Year
o.	at the de by the a stached i	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time or de	atn 5∟	Other (specify) _						
P.0	that the ed by detac		Part II. Other significant conditions co	ntributing to death b	ut not resu	lting in the ur	iderlying cause giv	en in Part I		23e. Did to	obacco use c	contribute to th	e cause of death?
ds,	sign d be	d by								1 🗀 Y	′es 2 🗆 No	o 3 D <b>x</b> Prob≀	ably 4 ∐Unknown
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Vit	ician: certific rector,	Be	25. Was case referred to medical examiner?	lospital:			Ott	00		Check only o			
of Vital Records,	Phys this aldi	<u>۲</u>	1 Xyes 2 No	1 ☐ Inpatie		ER/Outpatien 28b. Time of	1 3 DOA	4 LINU	_	5 □ Resid d. Describe h		Other (Specify	")
u	ding h. After funer	ig	1 Natural 5 ☐ Pending	(Month, Da)	y Year)	Injury	28c. Injui Woo M 1	k?` Yes 2⊟.		a. Describe ii	ow anjury co	burred	
isi	deatl deatl ctor: y the	lica	3 Suicide 6 Could not be	28e. Place of Init	urv - At ho	me farm stre				f. Location (S	Street and Nu	umber or Rural	l Route Number,
Division	after Dira	Certification;	4 ☐ Homicide determined	28e. Place of Inju- building, etc	c. (Specify	)	ou, radiory, omoo			City or Tow	n, State)		. Hosto Hambol,
_	a Hospital or Attanding is 24 hours after death. 2 Hours all Diractor: After etely filled in by the funer		29a. Certifier 1 ☐ Certifying Phy	sician: To the best	of my know	vledge death	occurred at the til	ne date an	d place, and	d due to the o	ause(s) and	manner as st	ated
	To tha Hospital or Attanding within 24 hours after death.  To tha Funaral Diractor: After completely filled in by the fune.	edical	(Check only 2 Medical Exami		examinat								
	To tha	Me	29b. Signature and title of certifier	\			29c. Licens	e number		1	29d. Date sig	gned (Month, D	Day, Year)
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	J		30. Name and address of person who co	ompleted cause of d									
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	Sta	ate	31. Date filed (Month, Day, Year)	02.1109	with culdurar	u.o							-
	Registi	rar	SEP 3	2004	Deck -	K	A. C.						

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THOMPSON, RAYMOND

			State	state of Maryl	Car	artment of		Mental Hy	0001	
			RegistrarAMFND#3perMD9/2/2	0004, BMW, MbCb	Cei	rtificate o	t Death	2. Date of De	Reg. No.	<u> 29526</u>
	Physicia		Decedent's Name (First, Middle, Last)  T T.					Month	Day Year	3. Time of Death
	/Medic		Jane Tt	et and number)		4b. City. Town	, or Location of Dea	August	21, 2004 4c. County of Dea	9:00 A <sup>M</sup>
	Examin	er	9221 Laurel Oak Driv				hesda		Montgon	
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Day	ar If Under 24 Hrs			rthplace (State or Foreign ountry)
	Director		051-18-0758	2₹ F	31 Yrs.	MOTITIS Day	S Hours Mill	Nov. 3	0,1922 New	7 York
	pui 🛊	}	Usual Residence of Decedent  10a, State 10b, County	10c	City, Town or Lo	cation				10d. Inside City Limits
	Manylis I sho	ō								1 ☐ Yes 2 X No
	the h	Director	Maryland Montgomer  10e. Street and Number	у	Bethes	10f. Zip Code	)		10g. Citizen of What C	ountry?
	3e or		9221 Laurel Oak Dri	ve		2	0817		United Sta	ates
	death	nera		Was Decedent Ever in Armed Forces?	n U.S. 13.		f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No		erican Indian,
9	after or ite	by Funerai	1 Never Married 2X Married	1 ☐ Yes 2 No If Yes, Give	i	1 ☐ Yes 2X N		to Hoari, etc.)	Specify: Wh:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examinating the rediffed at		3 Widowed 4 Divorced	Year or Dates:						
2	"nat	Completed	15. Decedent's Educat (Specify only highest grade of		16a. Deced (Give	dent's Usual Occ kind of work dor DO NOT use reti	cupation ne during most of wo ired)	orking	16b. Kind of Business	VIndustry
7	withi	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemak			Home	
D S	Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
lan	uld be Aenta rked tic ev	ToB	Bernard Timoney				Jane Ga	vin		
Maryland	and Nama		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Stre	et and Number or R	ural Route Numbe	er, City or Town, State,	Zip Code)
Σ,	and sealth		John Turner/Husband	1			Oak Drive		da, MD 2081	
Baltimore,	I of H		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Rem		<ul> <li>b. Place of Dispo cemetery, crer.</li> </ul>	isition (Name of natory or other p	alace)	Date	20c. Location - City or	Town, State
Ē	then then tant:		`4 □Donation 5 □Other (Specify)	L			atory 08/			
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumetic event. It. Medical Examble must be rollified at once.		21. Signature of Funeral Service Licensee	h- Shady	- 110	40 Rock	ville Fik	e; kockv	Cremation ille, MD 20	Center 0852
	F D-PO		23a. Part1. Enter the d sease, or complicate shock, or heart failure. List only one of	ions that caused he d cause on each line.	leath. Do not ent	er the mode of d	ying, such as cardia	c or respiratory ar	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a a	Intersti	tial Pul	monary :	Fibrosis			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):					
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,					
Ć,	exector and and rial-tra		resulting in death) Last	Due to (or as a con	sequence of):					
68760,	death certificate be executed e attending physician and od for use as the burial-transit	ical	d							
89	ntifica ng ph	Med	IF FEMALE:							
Вох	ath ce titend or usi	Physician/Med	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnar			23d. Date of de Month	livery Day Year
0	0 0	ysic	1 ☐ Yes 2 🌠 No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	ordeath 5L	Other (specify)				•
<u>α</u>	The law requires that the ate has been signed by th bage 2 should be detache	/ Ph	Part II. Other significant conditions contril	outing to death but not	resulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	uires sign ld be	d by						101	res 2□No 3□P	robably 4 XUnknown
00	w require s been si should l	Completed						24a. Was		utopsy findings available
	The fa te has age 2	omp						autop perfo 1 ☐ Yes	rmed? death?	completion of cause of
Vital	lan: rtifica stor, p	ø	25. Was case referred to medical				26. Place of De	ath (Check only o		20110
	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2X No	pital: 1 🗌 Inpatient 🔞	2 ☐ ER/Outpatien	nt 3□ DOA	Other: 4 Nursing I	Home 5 X Resid	dence 6 Other (Spe	ecify)
n of	ng Pl		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	W		28d. Describe h	now injury occurred	
Sio	Attending or death.	cati	2 Accident investigation	no Diversitation (	MA hama - 1 - 1		Yes 2 No	204 Leasting (6	Street and Mumber - 7	
Division	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)	eet, factory, offic	:8	City or Tox	Street and Number or R. vn, State)	urai Houte Number,
	Hospitel or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1X Certifying Physic	an: To the best of my	knowledge, death	n occurred at the	time, date and place	e, and due to the	cause(s) and manner as	s stated.
	the Ho	edical	(Check only 2 Medical Examiner one)							
	To th withir To th comp	Me	29b. Signature and title of certifie	Λ		29c. Lice	nse number		29d. Date signed (Mont	th, Day, Year)
-	15		) () () W	12		I	026571		August 25,	2004
	17		30. Name and address of person who comp							
				0215 Fernwo		; Suite	401; Beth	nesda, MI	20817	
	Sta Registr		31. Date filed ( <i>Month, Day, Year</i> ) <b>SEP 0 2</b> 2004		-	Spars	h			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death OOSO7 Reg. No. | 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Mildred Irene Turner 13:25 M September 06, 2004 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 1 F Yrs. 215-26-6800 Director 76 July 09, 1928 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10a. State Show 10c. City, Town or Location 10d. Inside City Limits ortant: if itam 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic evant, the Nadical Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19401 Dans Rock Road 21532 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Mental or other traumatic event. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert W. Dye 2 Ruth J. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Michael Turner-Husband 19401 Dans Rock Road, Frostburg, Maryland, 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State September 4 □ Donation 5 □ Other (Specify) Frostburg Memorial Park 09, 2004 Frostburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. 7ah1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Ventricular /Medical Due to (or as a consequence of) Examiner Screre Choking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ous to (or as a consequence of) transit. The law requires that the death certificate be executed sollowing and that initiated events resulting in death) Last Due to (or as a consequence of): burial-t the attending physician in the physician P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 1 ☐ Yes 2 No 2 No 1 Yes Hospital or Attanding Physician: uneral director, 25. Was case referred to medical examiner?

1 \( \text{Yes} \) 2 \( \text{Y} \text{No} \) Be 26. Place of Death (Check only one) Hospital: Other: 2 2 ■ ER/Outpatient 3 □ DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funaral Director. in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Y

Year)

1 6 2004

32. Resstrar's Signature

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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31

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Lawrence S. Lessin, M.D., 110 Irving Street, NW, Washington, DC

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MICHAEL TYMENSKY Дау 30. T. . 2004 August 10:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 159 Corning Lane Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 2,1951 5. Social Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 373-56-0907 53 Maryland Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Md. Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö 159 Corning Lane 20878 23a United States by Funeral death 12. Was Decedent Ever in U.S. Amed Forces? 1 ZYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates 968-1995 3altimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No White Specify. 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Naval Aviator U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fund Mental I Is marked c Fern Duncan Leo Bernard Tymensky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Department of Health and
Important: If Item 27 Is m
any injury or other traum
once. Catherine G. Tymensky (Wife) 159 Corning Lane Gaithersburg, Md. 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 🖺 Burial 2 🗆 Cremation 3 🗀 Removal from State 20c. Location - City or Town, State Date Oct. öh Arlington National Arlington, Va. <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 2004 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, Md. 20878 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CEREBRAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner GLIOBLASTOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit certificate be executed and Due to (or as a consequence of) ed by the attending physician detached for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, law requires 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 💢 No Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending Injury 1 XNatural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ D-47855 SEP - ( 2004 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER JOHN R. GILSTAD LCDR MC USN BETHESDA MD 20889-5600 32. Registrar's Signature State sacks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 1833 M ABY GIRLTUONG 2, 2004 rodem ber /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner B C Hours Min. (Month, Day, Yeer) t-Agnes Care Health 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 20 F SEPTEMBER 2,2004 MARYLAND NIA Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Nos 2 No MD BALTIMORE, MARYLAND **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2512 A CHESHAIRE DRIVE UNITED STATES 21244 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after Never Married 2 Married 1 ☐ Yes No Specify: ORIENTAL Specify: If Yes, Give Year or Dates Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NIA Hygiene. NIA NIA NIA marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental 8 KEVIN KIEUHANG TUONG TUONG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 19a. Informant's Name/Relationship (Type, Print) 2512 A CHESHAIRE DRIVE BALTIMORE, MD. 21244 KIEUHANG, TUONG/MOTHER Health permit. Pages t and Department of Healt Important: If item 2 eny injury or other other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete OCTOBERI, BALTIMORE, MO Pages nent of h Burial 2 Cremation 3 Removal from State NEW CATHEDRAL CEMETARY \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ST AGNES HEACTHCARE De advantorg per su e Lynn 9005 CATON AVENUE BALTIMORE, MD. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physician and s the burial-transit requires that the death certificate be executed resulting in death) Last Physician/Medical SE the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown NONE Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy performed? certificate 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 20 No 1 Tyes 1 inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospitel or Attending Ph 4 hours after death. Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) Certification: 1-Natural 5 Pending investigation Injury NA 1 ☐ Yes 2 No NIA 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide N NI within 24 hours a To the Funerel [ Hospite 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certified 30. Name and address death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month State Registrar DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore.

Box 68760.

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Vital

Division of

		•	For Stete Registrar	State of Ma	ryland /	-	artment o			nd Menta		ene 1. No. 0 (	) 4	29531
	Physici		Decedent's Name (First, Middle, I ROBERT GEORGE	Last) VALENTINE							e of Death oth LPT.	Pay 20	O <sup>Year</sup>	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g 8354A MOUNTAIN				4b. City, Tov		cation of C			4c. County	of Death	HINGTON
	Funeral Director		5. Social Security Number 219-36-4336  Usual Residence of Decedent	. Sex 7. Age 1 M 2 □ F	(In yrs. last i	birthday) Yrs.	If Under 1 Y Months D		Under 24 lours	Hrs. 8. Date (Mo	e of Birth inth, Day, Y	<sup>(ear)</sup> 1939	9. Birth Cou M	place (State or Foreign intry) ARYLAND
	Maryland	tor	10a. State 10b. County	HINGTON	10c. City, To	own or Lo	cation	ВО	ONSBO	ORO				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the a or 28¢	Directo	10e. Street and Number	TAUDEL DOAD			10f. Zip Co	de	0171	1.0	10g	. Citizen of		-
36	within 72 hours after death with the Maryland ene. Itan "natural", or itams 23a or 28e-f ehow ita Madicul Evati in ar musi ke molifikad al	by Funeral	8354A MOUNTAIN  11. Marital Status  1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces?		1	Was Decedent f Yes, specify 1 ☐ Yes 2∑		2171 nic Origin fexican, P pecify:	L 3 i? (Specify Ye Puerto Rican, e	s or No- atc.)		ce - Amer ck, White	S.A. ican Indian, , etc.
21215-0036	within 72 hou ene. than "nature I a Madicul E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+		a. Deced (Give life.	dent's Usual O kind of work a DO NOT use n	bne durin eti <b>r</b> ed)	g most of	f working		Sb. Kind of B	usiness/Ir	ndustry
Maryland 2	ould be filed Mental Hygis arked other atic event, I	To Be Co	17. Father's Name (First, Middle, La HERMAN E. VALEN					18.	Mother's	Name (First, ERINE E	Middle, Ma	iden Surnan		
nore, Mar	permil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Beginner in the 27 is merked other than "natural, or thans 23a or 28e-f show any injury or other traumatic event, the Medical Exacting the must be nutilized at once.	The state of the s	19a. Informant's Name/Relationship PATSY A. VALENT 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	CINE, SPOUSE	20b. Place	8354 of Dispo tery, cren	A MOUN sition (Name of natory or other	TAIN of place)	LAUF	REL ROA Date	D, BC	ONSBO	RO I	MD 21713 own, State
Baltimore,	permil. Pa Departmer Important any injury once.		21. Symmetric of funger Service See  22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 21713											
	Pnysician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or as a	consequenc	ee of):	er the mode of		ich as car	rdiac or respira	atory arrest			Approximate Interval Between Onset and Death
8760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Lisasso whur, that initiated events resulting in death) Last	Due to (or as a Due to (or as a d.										
P.O. Box 6	the death certific y the attending p ched for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal dea		Ectopic pregn						te of deliv	ery Day Year
rds, P.	w requires that the de- been signed by the a should be detached f	þ	Part II. Other significant conditions	contributing to death but	not resulting	in the un	nderlying caus	e given in	Part I.	236				he cause of death?
Division of Vital Records,	The law re ate has bee page 2 sho	Completed				-				-	a. Was an autopsy performed	d?_  (	death?	opsy findings available impletion of cause of
Vita	/sicien: s certific director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 □ ER/0	Outpatien	t 3□ DOA	Other	Place of	Death (Check		e 6 □Oth	er (Specii	(v)
sion of	To the Hospital or Attanding Physicien: The I within 24 hours after death. To the Funarel Director: After this certificate he completely filled in by the funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day )		. Time of Injury	28c.	Injury at Work? 1  Yes				injury occurr		,,
<u>Š</u>	oital or Attaurs after de rel Directe illed in by t	Certification:	3 Suicide 6 Could not determine	building, etc.	(Specify)					City	or Town, S	State)		al Route Number,
	he Hospital in 24 hours a ha Funarel I pletely filled	Medical	29a. Certifier 1 ☐ Certifying I (Check only one)	Physician: To the best of aminer: On the basis of e and manner state	xamination a	ge, death and/or inv	estigation, in r	ne time, da my opinior	ate and pl n, death c	place, and due occurred at the	to the caus time, date	se(s) and ma and place, a	inner as s and due t	tated.  the cause(s)
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	1. Mular	1	MV		cense nur	nber 166	~	29d.	Date signed	(Month,	Day, Year)
	3		30. Name and address of person wh											.)
5	Sta Registr	te ar	30. Name and address of person when the state of the stat	2004 32. Registrar	s Signature	- 11	ales	106	dice	ol (6	anje	· s //	zser.	iloun My

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer 5:20AM M Henry Carlton Wheelock September 2004

**Funeral** Director

**Physician** 

/Medical Examir

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. sont: If Item 27 is marked other then "naturel", or Items 23a or 28e-1 show

Baltimore, Maryland 21215-0036

**Physician** /Medical

Division of Vital Records, P.O. Box 68760,

Division of Vital Records, P.O. Box 68/60,	To the Hospitel or Attending Physicien: The law requires that the death cartificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit
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er	4a. Fecility Name (if not institution, give	street and number)		4	b. City, Fown,	or Location	of Death		4	ic. County of De	eath
	1800 Londontown	Circle			Hagers	stown				Washing	ton County
	5. Social Security Number 6. Se	ex 7. Ag	e (In yrs. last birl		f Under 1 Year lonths Days		Min.	8. Date of E (Month, I	Birth	9. E	Birthplace (State or Foreign Country)
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	Usual Residence of Decedent										rratio
	10a. State 10b. County		10c. City, Town	n or Locat	ion						10d. Inside City Limits
ţ	Maryland Washing	ton	Нас	erst	Orano						1 ☐ Yes 🏖 No
ec C	10e. Street and Number	COIT	nag		10f. Zip Code				10g. C	Citizen of What	Country?
₫	1800 Londontown	Circlo			217	7.40					ooutiny.
ra			5	10.111						J.S.A.	
ŭ	11. Marital Status	12. Was Decedent Armed Forces?		If Y	s Decedent of es, specify Cub	an, Mexica	an, Puerto R	lican, etc.)	NO-	Bleck, Wi	nerican Indian, hite, etc.
γF	1 Never Married 2 Married	1 XXXes 2 ⊡ t If Yes, Give	No	1 🗆	Yes 2⊠ No	Specify	<i>y</i> :			Specify:	White
Be Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates:									
ete	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a.	(Give kin	t's Usual Occu d of work done NOT use retire	pation during mo	st of workin	g	16b.	Kind of Busines	ss/Industry
dr.	Elementary/Secondary (0-12)	College (1-4or 5		_		ed)					
ပိ	12			Macn.	inist						overnment
3e	17. Father's Name (First, Middle, Last)					18. Moth	ner's Name	(First, Midd	le, Maide	en Sumame)	
2	Henry Carlton Whe	етоск				Marc	nerit	e Cha	rlot	te Bart	ala
'	19a. Informant's Name/Relationship (7	ype, Print)	19b.	Mailing A	ddress (Stree	and Numb	ber or Rural	Route Num	ber, City	or Town, State	, Zip Code)
	Barbara Ann Wheel	ock/Wife		180	0 Londo	ntown	Circ	lo us	aore	torm Ma	ryland 21740
	20a. Method of Disposition	OCH WILC	20b. Place of	Disposition	on (Name of		Da	ite		Location - City	
	1 ☐ Surial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify				Mom	1	Cont	0 20	4 71	·	Wasselland
	21. Signature of Funeral Service Licen		Ceual		ame and Addre						wn Maryland
	De la	1 thul	·To				DOU	glas	A. F	iery Fu	neral Home
	, willing	I (UNVUE)	11-							own Mar	yland 21742
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each li	ithe <del>d</del> eath. Do r ne.	not enter t	he mode of dy	ng, such as	s cardiac or	respiratory	arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	Metas	tanic	Cen	e ca	Cià	0000				Onset and Death
	resulting in death)	Due to (or as	a consequence	of):			91.10	_			gails
		b									
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	of):							
Sequentiary   Sequentiary											
Exa	resulting in death) Last	Due to (or as	a consequence o	of):							
le		d									
gdic		· · · · · · · · · · · · · · · · · · ·									
/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy							23d. Date of d	alivan
iar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		topic pregnanc her (s <i>pecify</i> )	У				Month	Day Year
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or doutin	3000	(ioi (specify) _						
P	Part II. Other significant conditions co	ontributing to death b	ut not resulting in	the unde	rlving cause gi	ven in Part	1	23e Did	Itobacco	use contribute	to the cause of death?
			at the rooming in	and ando	nying oddoo gi	voit at t ait	1.			- 4	
ted	Hapertusiun	)						, ,	Yes :	2 NO 3	Probably 4 Unknown
ple								24a. Wa	s an opsy	24b. Were a	autopsy findings available completion of cause of
no.								per 1 Yes	formed? 2 <b>2</b> N	death?	es 2 No
Be Completed	25. Was case referred to medical					26. Plac	e of Death (				
To B	examiner? 1 ☐ Yes 2 X No	Hospital:	nt 2 ER/Out	patient	3□ DOA Ot	ner	ursing Homi			6 ☐ Other (Sp	ecifu)
	27. Manner of Death	28a. Date of Inju	ry 28b. T	ime of	28c. Inju Wo					ury occurred	oony,
tloi	1. Accident 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da)	/ Year) Ir	njury		rk? ]Yes 2. [	]No				
fica	3 Suicide 6 Could not be		ury - At home, far	m. street.	factory, office		28	Bf. Location	(Street a	nd Number or F	Rural Route Number,
erti	4 Homicide determined	building, etc	c. (Specify)		,,			City or To	own, Sta	te)	,
Č	29a. Certifier 12 Certifying Phy	ysicien: To the best	of my knowledge	death co	ourred at the fi	me data a	nd place an	d due to th	0.001100/	e) and masses	o details as
dica	(Check only 2 Medicel Exem	iner: On the basis of and manner sta	examination and	or invest	igation, in my	opinion, dea	ath occurred	at the time	, date ar	nd place, and du	ie to the cause(s)
Medical Certification:	29b. Signature and title of certifier	and manner Sta			29c. Licens	se number			29d D	ate signed (Mor	oth Day Year
_								1		-	, say, real/
	Doub Brown	راس			000	576	00		1)	3/04	

State Registrar Smithsburg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hersin Block

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #22 per fh g835 99 privility at graft Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 23.55 Matthew Christopher Jugust /Medical Weitzel 24 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 54 U/364M NICOMICO PENINSULA KEGIUNAI MEDIEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/25/1986 5. Social Security Number **Funeral** 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ★M 2 ☐ F 17 Director 216-17-4931 Maryland Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 926 Snow Hill Road 21804 or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumatic avant, the Medical Examiner of 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No **À** Specify: white 3 Widowed 4 Divorced natural Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Severely Handicapped n/a 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important; if Itam 27 Is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gordon M. Weitzel Jr. Mary Helen Nibblett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon M. Weitzel Jr/father 12370 Vivian St., Bishopville, MD 21813 other t 20b. Place of Disposition (Name of cometer), crematory or other place)
Wicomico Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State □Donation 5 □ Other (Specify) 8/30/2004 Salisbury, MD avid A. Kong 22. Name and Address of Facility HOLLOWAY FUNERAL HOME PROFESSIONAL SERVICES 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** colitis disease or condition resulting in death) 24 hours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ician and burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐ Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ re terdatur Be Completed 1 Yes 2 No 3 Probably 4 Unknown dehydration 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 autopsy performed? Division of Vital 1 Yes 2 🗌 No Yes 2 □ No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 ☐ No Other: Certification: To 1 Impatient 2 ER/Outpatient 3 DOA □ Nursing Home 5 □ Residence 6 □ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Diractor: 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 - Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 26/04 D3085 Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Silvia, Jr MD 100 Power St. SAlisbury, md 21804 AUG 27 2004 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					arylanu ———	Certificate		F	leg. No	04 2	9534
	Physici	an	Decedent's Name (First, Middle, La  Eula	as <i>t)</i> B.	\//i	lliamson		2. Date of Dea Month Sep 11	Day	Year	îme of Déath 5am
	/Medio Examir		4a. Facility Name (If not institution, git			marrison	4b. City, Town, or		4c. County	of Death	<u> </u>
			Frostburg Village			Frost		T =	Alleg		
	uneral irector			Sex 7. Ag 1□ M 2□XF	ge (In yrs. las 86	t birthday) If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth Month, Day Feb 2	5, 1918	9. Birthplace (\$	State or Foreign
rytand	how		10a. State 10b. County	nnv	10c. City,	Frostburg					side City Limits ☐ Yes 2 ☐ No
he Ma	28a-f s	ecto	MD Allega		<u></u>	105tDa1g	nda .		10g. Citizen of V		- X
ath with t	23a or 2 vust be n	Funeral Director	1 Kaylor Circle				21532		U	SA e - American Ind	lian
should be filed within 72 hours after death with the Maryland	important: if tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>م</u>	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	No	If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	o Rican, etc.)	Specify	ck, White, etc.  white	
72 h	"natu	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Decedent's Usual O (Give kind of work of	eccupation fone during most of wor etired)	rking	16b. Kind of Bu	usiness/Industry	
withir	than N	duc	Elementary/Secondary (0-12)	College (1-4or	5+)	Laborer	0.11.00)		Textile		
d be filed	ed other c event,	Be	17. Father's Name (First, Middle, Las George Robert		,			me <i>(First, Middl</i> e, Lee Heav		•	
nd 2 shoul	27 is mark r traumati	2	19a. Informant's Name/Relationship Debbie Herndon		ghter	19b. Mailing Address (S 34 Green I	treet and Number or Ri Meadow Ct.	ral Route Numbe Pitts	r, City or Town, DO <b>rO</b>	State, Zip Code NC	27312
Dentition C, man grant E.E. C. C. Somit. Pages 1 and 2 should be filed within 72 hours aft became of Health and Mental Horisone	nt: if item ry or othe		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Spec		cen	ce of Disposition (Name netery, crematory or othe rest Memorial F	r place)	Date 9/13/2004		city or Town, Si erland	MD
permit.	Importal any Inju		21. Signature of Funeral Service Lice	A e 10 k	011		rpelli Funeral I Virginia Aven			21502	
		Н	23a Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that cause	d the death.					Appro	oximate val Between
	sician					1		1			t and Death
	ledical aminer		Immediate Cause (Final disease or condition resulting in death)	a	NGE	STIVE He is a consequence of):  JARY AR	ARI HAI	LURE		2	weeks
		ē		0	Due to (or a	is a consequence of):	TERU D	18EAS	E	1	
executed	n and ial-transit	Exami	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		s a consequence of):	7,		-		
ertificate be executed	ding physician and se as the burial-transit	/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a	s a consequence of):					
eath cer	attend For us	cian	Date Office significant conditions		out not rocult	ing in the underlying cause	eo given in Part I	23h Did t	ohacco usa co	ntributa to tha c	ausa of death?
requires that the death cer	igned by the attendir be detached for use	Physician/N	Part II. Other significant conditions	/		FARCT CUR			res 2□No	3 Probably	4 ⊡ Unknow
es tha	gned be de	by P	Ran	ewer z	100	FMTO)	Tana				
requir	been signatures	eted						24a. Was	an autopsy med?		prior to on of cause
e law	has Je 2	Completed						101	es 2 No	of death	_
Physician: The law requires to	certificate ha rector, page	ပို	25. Was case referred to medical				26. Place of De	ath (Check only o		10.100	
Physician:	is cert direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ient 2 🗆 El	R/Outpatient 3□ DOA	Other:	lome 5 ☐ Resid		er (Specify)	
- 0	ter th		27. Manuer of Death  1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da	ury ay Year)	8b. Time of 28c. Injury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occur	red	
or Attending	ctor: y the	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e. Place of In	njury - At hom tc. (Specify)	ne, farm, street, factory, o	ffice	28f. Location (S City or Tow		per or Rural Rout	e Number,
a Hospita	Vitrin 24 fours area To the Funeral Directory completely filled in b	edical C	29a. Certifier 1 Cartifying F (Check only one) 2 Madical Exe	Physician: To the best aminar: On the basis of and manner s	of examination	edge, death occurrad at an and/or investigation, in	the time, date and place my opinion, death occu	e, and due to the curred at the time,	cause(s) and ma date and place,	anner as stated. and due to the c	ause(s)
To th	To th comp	Me	29b. Signature and title of certifier	aven	,	7	icense number  2563	8	Sent.		004
			30. Name and address of person wh	o completed cause of	death (Item 2	23a) (Type, Print)			1		
حين			Saturnina Char	ng M.D.	trar's Signatu	23a) (Type, Print) 10701 New	George's C	reek SW	Frostbu	irg MD 2	1532
	St Regist	ate rar	SEP 1 6	2004	arar s aignatu	1 Local					
			Ari I A	100	20 700						

DHMH 16 Rev 6/95

			For State Registrar	State of Ma	ryland	-	urtment of H		nd Menta	l Hygien		20000
	-:		1. Decedent's Name (First, Middle, Las	st)					2. Date	of Death	ay Year	2. Time of Death)
	Physicia /Medic		MICHAEL JOHN WIN	TER						ÜST 30	, 2004	1:40 PM
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location o	f Death	4	c. County of De	ath
			GARRETT COUNTY M	EMORIAL HO	SPITA	L	OAKLAN				GARRETT	
	Funeral Director		5. Social Security Number 6. S 161–18–3039 1 Usual Residence of Decedent	ex 7. Age ⊠M 2□F 82		yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date	of Birth orth, Day, Yea 22, 1	9. 8 920 PA	irthplace (State or Foreign Country) A
	and and		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Manyl f sho	ō	MD GARRE'	rт		SWANT	ΩN					1 □ Yes 2 ☑ No
	the the 28a-	rect	10e. Street and Number			DWAIT	10f. Zip Code			10a. C	Citizen of What C	
	Sa or	Funeral Director	959 HAZELHURST RO	OAD			2156	.1			USA	,
	Jeath Tis 2:	era	11. Marital Status	12. Was Decedent I	Ever in U.S	S. 13. V	Was Decedent of H f Yes, specify Cuba		in? (Specify Yes		14. Race - Am	nerican Indian,
920	d within 72 hours after death with the Maryland siener. It han't natural', or Items 23a or 28a-f show the Madical Examiner must be notified at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☑ Yes 2 ☐ N  If Yes, Give  Year or Dates:	o WW I		fYes, specify Cuba I⊡Yes 2 🛣 No	Specify:	Puerto Rican, e	etc.)	Black, Wh	ite, etc. WHITE
5	2 ho	ted	15. Decedent's Ed	ducation		16a. Deced	ient's Usual Occup	ation	-4	16b.	Kind of Busines	s/Industry
7	7 in 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done of OO NOT use retired		or working			
, ,	TO 10 10 10 10 10 10 10 10 10 10 10 10 10	5	12			SERV	ICE MANAG	ER		AU'	TO DEALE	ERSHIP
<u> </u>	be file tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)					18. Mothe	's Name (First,	Middle, Maide	en Sumame)	
<u> </u>		2	JOHN	W	INTER			ELIZ	ABETH		F	ROLLINGER
Mar	s 1 and 2 should if Health and Mer item 27 is marke other traumatic	•	19a. Informant's Name/Relationship ( ELEANOR WINTER -				ng Address <i>(Street :</i> HAZELHURS				or Town, State, MD 2156	
ē,	s 1 a if Hez item othe		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of natory or other place	(e)	Date		Location - City o	
Ē			1 🖾 Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specif				EMORIAL (	-	9/3/04	0/	AKLAND.	MARYLAND
	mit. Page bartment c cortant: If injury or		21. Signature of Funeral Service Licer				. Name and Addres			2.0. B		
מ	Ped in a ga		Mobile 14/	unt 1	M0016	7 1	OURST FUN	ERAL				550
۳			23a. Part1. Enter the disease, or com	plications that caused	the death.						,	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each in	10.	ha	achit.	-				Interval Between Onset and Death
•	/Medical		disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	nconn	>	<u> </u>			2 caup
	Examiner			ACI	ti	le	Rt hear	x+	rilin	1		2 days
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):		- /				- cup
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	en	1/1	use	ma	,				years
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9	te be ysicia e bur	cal		d al	rtic	- sta	non					years
	certificat nding phy use as th		San									
ŏ	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7e				23d. Date of de	elivery
ă	death e atten ed for u	icia	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)				Month	Day Year
j	oy the	hys	9 ☐ Unknown	9□ Unknown								
ທ໌ ໄ	requires that the des een signed by the a hould be detached f		Part II. Other significant conditions of	contributing to death b	ut not resu	Iting in the u	nderlying cause give	en in Part I.	236	e. Did tobacco	use contribute	to the cause of death?
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	i <b>ician</b> : Th certificate rector, pag		25. Was case referred to medical					26 Place	of Death (Check	Yes 2	lo 1 □ Ye	s 2 No
5	Physician: r this certific ral director,	To Be	examiner? 1 □ Yes 2 ▼No	Hospital: 1 Mapatie	nt 2 🗆 E	R/Outpatier	t 3 DOA Oth	or			6 □Other (Sp	ecifu)
	g Phy erthi eral c		27. Manner of Death	28a. Date of Inju	ry	28b. Time of				scribe how in		outy
0	th. TAfte	tio	1 Natural 5 Pending 2 Accident investigatio	(Month, Da)	y Year)	Injury		k? Yes 2 <mark>□</mark> 1	10			
DIVISION	al or Attending Physis after death. I Diractor: After this of in by the funeral dir	iffica	3 ☐ Suicide 6 ☐ Could not be determined		ury - At hor	me, farm, str	eet, factory, office					Rural Route Number,
5		Certification;	Tionicide	Duilding, et	с. (Эрвспу,	,			Chy	or Town, Sta		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	nysicien: To the best miner: On the basis of and manner sta	examinati	vledge, deatl ion and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, and due h occurred at the	to the cause time, date a	s) and manner and place, and du	as stated. ue to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier	- 11	2		29c. Licenso	e number		29d. C	ate signed (Mor	nth. Dey, Year)
			Maisteris	1 a Kur	4/	20	Di	2660	50	9	8/30/	2004
			30. Name and address of person who	completed cause of d	eath (Item	23a) (Type.	Print)				1	
			marganis Ku	isen me	6	307	garret	# A.X	luva-	ach	land.	2004 UD 21550
	Sta	ate	31. Date files (Month, Day, Year)	32. Registr	s Signat	ure AS	Penes	1				

			For State Registrar	State of M	Maryland	-		t of H	ealth a				004	2953	6
	Physici	an	Decedent's Name (First, Middle, La								2. Date of De Month	ath Day	Year	3. Time of Dea	ath
	/Medic	al	James William W								August	31	2004	12:30A	М
	Examin	er	4a. Fecility Name (If not institution, giv		er)		,	Town, or ${f xvil}1$	Location of	of Death			County of Death		
	F		605 Tritapoe Dr 5. Social Security Number 6.5		Age (In yrs. la	st birthday)	If Under		If Under:	24 Hrs.	8. Date of Birt		rederic	place (State or Fo	roian
	Funeral Director			M 2□F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Oct 10	y, Year) 192	Cou	y Ridge	-
	Maryland 6-f ehow	ctor	MD 10b. County Freder	ick		Town or Lo								10d. Inside City Li 1 ☐ Yes 2X	
	th with the 23a or 28 st be no	Funeral Director	10e. Street and Number 605 Tritapoe Dri	ve			10f. Zip	Code 217	58			10g. Citiz	en of What Cou USA	intry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28e-f show any injury or other treumatic event, The Modical Ever in ast must be multified at ODGE.	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 🔀 Yes 2 [ If Yes, Give Year or Date:	s? ⊒ No		Was Deced f Yes, spec 1 ☐ Yes 2	ify Cuba	spanic Orion, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: Wh:	, etc.	
Maryland 21215-0036	I within 72 ho iene. r than "natur ine Medical.	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4c	or 5+)	lite. I	dent's Usua kind of wor DO NOT us Carma	rk done d se retired,	turing most	t of workii	ng		d of Business/li	ndustry Terminal	. Co
and	ld be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last George William M								(First, Middle,				
Mary	d 2 shouth and M	_	19a. Informant's Name/Relationship (										Town, State, Zi		
	ages 1 and of Healint of Healint 1: If Item 2		20a. Method of Disposition 1 ⊠Burial 2 □Cremation 3 □	Removal from Sta	le i	ice of Dispo	sition (Nam natory or of	ne of ther place	в)	D	ate	20c. Loc	ation - City or T	own, State	
Baltimore,	permit. P Depertme Importen any injur		Park Heights Cemetery 9/2/04 Brunswick, MD  21. Signature of Funeral Service Licenses  Barbara A. Williams, Owner  Park Heights Cemetery 9/2/04 Brunswick, MD  22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716												
	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caus one cause on each	line.	Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death	h
	/Medical Examiner		resulting in death)  Sequentially list conditions,	b	RTEO	ance of):	Λυπι	V	45 64	CAM	DISTA	0		20 year	-5
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	as a conseque									ι	
8760,	icate be executed physician and s the burial-transit	ical	resulting in death) Last	Due to (or a	as a conseque	ence of):									
P.O. Box 6	ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal dat time of dea	leath 3□	Ectopic pre					23	3d. Date of deliv Month	ery Day Year	
	quires that the de in signed by the e uld be detached f	by	Part II. Other significant conditions	contributing to death					en in Part I.					he cause of death	
I Records,	The law requir ate has been si page 2 should	Completed				(					24a. Was autop	sy med⊋	prior to co death?	opsy findings avail impletion of cause	able of
/ita	ilcien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					. ,		of Death	(Check only o	ne)			
)   	Physic this c	L <sub>O</sub>	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa		R/Outpatien			4 🗆 1401				□Other (Special	(y)	
Division of Vital	ending F eath. or: After he tunera	ation	27. Manner of Death  1 Natural 5 Pending  2 Accident investigatio	n	Day Year)	28b. Time of Injury	M 28	3c. Injury Work 1 🗌 ۱	at ? /es 2 □ ħ		8d. Describe h	ow injury	occurred		
Dİ	tel or Attsno s after death el Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined		Injury - At hom etc. <i>(Specify)</i>	ne, farm, str	eet, factory	, office		2	8f. Location (S City or Tow		Number or Rur	al Route Number,	
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the tuneral director, page	Medical	29a. Certifier 1 ☑ Certifying Pl (Check only one) 2 ☐ Medical Exam	nysician: To the be niner: On the basis and manner	of examination	ledge, death on and/or inv	estigation,	in my op	inion, deat	h occurre	d at the time, o	date and p	place, and due to	the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	ans 1	ND		29c.	License	number 22	037	>	29d. Date	signed (Month, 2/200)	Day, Year)	
	5+1		30. Name and address of person who			23a) (Type,	Print)	VTM	AU	5	Br	win	1 ict	ns	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 2	32. Regis	strar's Signatu	re	5	doo	uls	,					

			For State Registrar	State of Maryl		artment of H		, ,	iene	00007
			Decedent's Name (First, Middle, Las	(1)				2. Date of Deat	h	3. Time of Death
	Physicia		Maurice	Michael W	ilhere,	Jr.		Month August	30, 2004	12:23 A. M
	<ul> <li>/Medic</li> <li>Examin</li> </ul>		4a. Facility Name (If not institution, give				Location of Deat		4c. County of Dea	
			Shady Grove Adven	tist Hospita	1	Rockvi	11e		Montgom	ery
F	uneral		5. Social Security Number 6. Se	ex 7. Age (In )	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			rthplace (State or Foreign ountry)
D	Director		160-22-7526	<b>⊠</b> м 2□ F   7	7 Yrs.			Dec. 19,		PÁ
pug	* _		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limits
fanyla	sho	5								1 ☐ Yes 2 No
the N	28e-	Director	Maryland   Montgome	iry	Derwood	10f. Zip Code		1	0g. Citizen of What C	ountov?
with	a or	ä	16729 Frontenac T	orrace		2085	5		United S	•
death with the Maryland	ns 23	Funerai	10/29 FIUITERIAC I	12. Was Decedent Ever i	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race - Am	
d fee	r ter	Fun	1 ☐ Never Married 2X Married	Armed Forces? 1⊠Yes 2 □ No 1	.945-			o Rican, etc.)	Black, Whi	te, etc.
15-0050 72 hours af	el', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes Give	.946	1□ Yes 2⊠ No	Specify:		Specify: W	hite
22 Pc	natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occupa	ation during most of wo	rkina	16b. Kind of Business	/Industry
7 E		npie	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired		9	_	_
N &	ygier 1, mer 1,	Completed		5+	Clas	ims Attori				e Company
yland	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M		
S pinor	narke natic	မ	Maurice		here, Si		- 144 - 5 2	Anne	Kennedy	T. 0. (1)
Mar d2st	h and 7 Is n traun		19a. Informant's Name/Relationship (7		-1				City or Town, State,	
1 and	Department of Health and Mental*Hyglene. Importents: If item 27 Is marked other then. Inspired to the read and the standard favorine must be notified at early injury or other traumatic event, the Modeal Examiner must be notified at some to the standard factor of the standard factor.		Susan M. Wilhere/ 20a. Method of Disposition		b. Place of Dispo	sition (Name of			od, Maryla 20c. Location - City of	
Baitimore,	いこの		1 ☐ Burial 2X☐ Cremation 3 ☐	Removal from State	cemetery, crei	matory or other plac	1			
	ntme nten njun		* 4 ☐ Donation 5 ☐ Other (Specify			tan Crema  2. Name and Addres				, Virginia
n a	Imp ony		Mh el m		1/				hersburg,	MD 20877
_	-		23a. Part1. Enter the disease, or comp	olications that caused the o						Approximate
Di-			shock, or heart failure. List only immediate Cause (Final	-						Interval Between Onset and Death
,	ysician Medical		disease or condition resulting in death)	a. Respiva  Due to (or as a con		ailure				minutes
Ex	aminer			b. Esophac	, ,	arcinom	00			months
	ja.	Jer	Sequentially list conditions, I any Jaumy to Innections cause. Enter Underlying Cause (Disease or injury	Diae to (or as a con		aranen	100	·		MONING
cuted	nd ransil	Examiner	that initiated events	c.						
j š	ian ar ırial-t	Ë	resulting in death) Last	Due to (or as a con	sequence of):					
ecords, P.O. Box 68/60, law requires that the death certificate be executed	physician and the burial-transit	dical		. d.						
ordific	ing p	0 1	IF FEMALE:		NI L. CROSS					
<b>BOX</b>	attending     for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
ا ه ه	by the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	or death 5	Other (specify)				,
J. Ihat	ed by detac	by Physician/M	Part II. Other significent conditions c	ontributing to death but not	t resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
<b>Hecords,</b> he law requires t	5 8					, , , , , , , , , , , , , , , , , , , ,		1 □ Ye	s 2□No 3□P	robably 4 Minknown
o Per	been sig	ete						24a. Was ar	24h Wara a	utanau findiana avallabla
The lay	ge 2	Completed				<del></del>		autops	v prior to	utopsy findings available completion of cause of
_ ⊢	his certificate has b I director, page 2 s	e Co	25. Was case referred to medical					1 ☐ Yes 2		2 □ No
	recto	00	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Othe	ar	th (Check only one	nce 6 □Other (Spe	neif.it
o y d	<b>₹</b> Ø	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injury	/ at	28d. Describe ho		City)
oniging.	th. : Affk e fun	tloi	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ir) Injury	M 1 □ \	K? Yes 2 □ No			
DIVISION for Attending	ecto ecto by th	Hic	3 Suicide 6 Could not be determined	28e. Place of Injury - / building, etc. (Sp		eet, factory, office		28f. Location (Str City or Town	reet and Number or R	ural Route Number,
الله الله	s afte al Dir ed in	Certification:	4   Homedo	building, etc. (3)	racity)			0 1 7 0 W	. Sielej	
DIVISION To the Hospitel or Attending	within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.		29a. Certifier  (Check only 2 Medical Exem	ysicien: To the best of my niner: On the basis of exam	knowledge, deat	h occurred at the time	ne, date and place	, and due to the ca	use(s) and manner a	s stated.
He H	iin 24 the Fi	Medicai	one)	and manner stated.	mination and or in					
Jo.	To COT	2	29b. Signature and title of certifier	Jugden 1	M.D	29c. License		0	ed. Date signed (Moni	n, Day, Year)
17	271						992	/	8/30/02	
			30. Name and address of person who				dava D-	·  111	m 20050	
	4.04		Dr. Aaron Snyder, 31. Date filed (Month, Day, Year)	M.D., 9901 N		center Dr	ive, Koc	KATTIE' I	ш. 2085U	
	Sta Registi		SEP 02 200	W	19	Spark	/			

ician			Certificate	of Death		leg. No.2 ()	04 29	9538
dical	Decedent's Name (First, Middle, Le  M.	ELIZABETH	YANCEY		2. Date of Dee Month AUG.	Dey	Year	me of Death :25 PM
niner	4a Fecility Neme (If not institution, giv	re street end number)	-	4b. City, Town, o	Location of Deeth	4c. County	of Deeth	
	SACRED HEAR		K Hadar 1	HYATTS Year If Under 24 Hr			CE GEORG	
al or		Sex 1 □ M 2 X F 7. Age (In y		Days Hours Mir		20,1907	9. Birthplace (S Country) VIRGIN	IA
	10a. State 10b. County	10c.	City, Town or Location				10d. fns	ide City Limits
Director	MD. PRINCE	GEORGES		TSVILLE				Yes 2□No
౼	10e. Street end Number	VIE #21/	10f. Zip C			10g. Citizen of V		
Funeral	5805 42nd A	VE. #314  12. Was Decedent Ever in	n U,S. 13. Was Deceder	20781 nt of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No-		S.A. e - American Indi	an,
þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	If Yes, specify		rto Rican, etc.)	Specify	ck, White, etc.  WHITE	
eted	15. Decedent's Ed (Specify only highest gre	ducation ede completed)	16e. Decedent's Usual ( (Give kind of work	Occupation	orkina	16b. Kind of Bu	usiness/Industry	
Completed	Elementary/Secondery (0-12)	College (1-4or 5+)		done during most of we retired) ICAL		RITT	LLDING	
Be Co	17. Fether's Neme (First, Middle, Last,	)	OLLE		ame (First, Middle,			
10 B	EDWIN LE	WIS YANCEY			EDITH N	f. THO	ORNTON	
	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing Address (S	Street and Number or F	Rurel Route Numbe	r, City or Town,	State, Zip Code)	
	M. ELIZABETH Y		5805 42n	d AVE. #31				
1	20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □	Removal from State	cemetery, crematory or other	ar place)			City or Town, Sta	
6	4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Liceral Service Lice		1	METERY Address of Facility	8-27-2004	CULPI	EPER, VA	•
olo	10/10/10/h	www. Al	CHAMBER	S FUNERÁL EVELAND AV				7
	23a. Part1. Enter the diseese, or com shock, or heart failure. List only	plications that caused the d					Appro	ximate al Between
ın	Shock, of Healt failule. List only							and Death
al er	Immediate Cause (Final disease or condition resulting in death)	. Sepsi	o (or as a consequence of):				!	
100		/ Due to	o (or as a consequence of):	1			-	
Examiner	Sequentially list conditions	b. Wrings	o (or as a consequence of):	1- enje	ection	7	1	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)			V			1	
dical	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to	(or as e consequence of):				1	
УMе		d						
iclar	Part II. Other eignificant conditions o	ontributing to death but not	resulting in the underlying cau	se given in Part I	23b Did to	obecco use co	ntribute to the ca	use of death?
by Physician/Medic	Polyeon 15.	g to doubt out 10t	and an activity any control of the control	greenin with			3 ☐ Probably	
by	10 me 20 1/12							
Ž.					24a. Was a perfor	n autopsy med?	24b. Were auto available p completio	prior to
=					579647		of death?	
mplete					ath (Check only or		1 □ Yes	2LI No
e Completed	25. Was case referred to medical			26 Place of Da	THE PARTY OF THE PARTY OF	101		
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑-No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3□ DOA	Other:	Home 5 ☐ Reside	ence 6 Othe	er (Specify)	
To Be	examiner? 1 ☐ Yes 2 ☑ No 27. Menner-of Deeth	Hospital: 1 Inpatient 2  28e. Date of Injury (Month, Dey Year,	28b. Time of 28c	Other: 4 Nursing . Injury at Work?				
To Be	examiner? 1 ☐ Yes 2 ☑ No  27. Menner-of Deeth 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	28e. Date of Injury (Month, Dey Year)	28b. Time of 28c Injury M	Other: 4 Nursing Injury at Work?	Home 5 ☐ Reside 28d. Describe he	ow injury occurr	ed	Abombee
To Be	examiner?  1  Yes 2  Avo  27. Menner of Deeth  1  Weturel 5  Pending 2  Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of 28c Injury M	Other: 4 Nursing Injury at Work?	Home 5 ☐ Reside 28d. Describe he	ow injury occurr		Number,
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Certification: To Be	examiner?  1	28e. Date of Injury - A building, etc. (Spe and manner stated.	28b. Time of Injury M  thome, farm, street, factory, cocify)  knowledge, death occurred et ination and/or investigation, in 29c. L	Other: 4 Nursing. Injury at Work? 1 Yes 2 No  Trice The time, date and place my opinion, death occidense number	Home 5 Reside  28d. Describe he  28f. Location (Si City or Town  e, and due to the courred et the time, d	treet and Number, Stefe)  ause(s) and mate and place, a	er or Rurel Route  nner es stated, and due to the ca	use(s)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** August 25, 2004 11:40P M Diane Susan Yalowitz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 1210 Highland Dr. f Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 8, Illinois Director 142-50-6324 49 Nov. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10b. County 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if Itam 27 is marked other than "netural", or Itams 23s or 28s-1 show amy picture or other traumatic event, the Modical Examiner was been callified at once. or 28a-f show 1 XYes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 U.S.A. 1210 Highland Dr. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Writer/Editor Publishing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Erin ၉ Max Granat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Highland Dr. Silver Spring, MD 20910 David Yalowitz/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Park | 8/27/2004 Falls Church, VA 21. Signature of Funeral Service Licensee Name and Address of Facility Hines-Rinaldi F.H. 11800 New Hampshire Ave. Silver Spring, MD 20904 23a 251. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Glioblastoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 🕍 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No page 1 Yes To the Hospital or Attanding Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a 29a. Certifier 1🕇 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D35996 08/26/2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, MD 2730 University Blvd. W. #400 Wheaton, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature **AUG** 3 0 2004 Registrar

			1 - For State Registrar	State of Maryla	nd / Depa <i>Ce</i> a	artment of H	lealth and <i>Death</i>		giene 2	004	29540
			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	V.	3. Time of Death
	Physici /Medic		Rodolfo A.	Yui				Month August	Day 27,200	Year 04	10:13 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, o	or Location of De	eath	4c. Coun	ty of Death	
			Frederick Memor			Freder				derio	ck
	Funeral Director		0/3-40-00/4	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		lin. 8. Date of Bir (Month, Da June 2	th 19, Year) 7, 1923	9. Birthp Cour Peru	place (State or Foreign htry)
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation					IOd. Inside City Limits
	daryli f sho	ō	Maryland Montgomer		-	ery Vill	a0e				1 ☑ Yes 2 ☐ No
	the /	Director	10e. Street and Number	- 7		10f. Zip Code			10g. Citizen of	f What Cou	ntry?
	3a or		9361 Chadburn Pla	ce		208	86		United		
	ms 2	nera		2. Was Decedent Ever in	U.S. 13.	Was Decedent of I	dispanic Origin?	(Specify Yes or No serto Rican, etc.)	- 14. Ra	ace - Americ	can Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or items 23a or 28a-f show amounts in items 20 and 20	by Funerai	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	i	nr Yes, specnny Cub 1. 1. TYPS 2. □ No				<sup>ack, White,</sup> ify: Lat	_
ğ	2 hou	Completed	15. Decedent's Educ	ation		dent's Usual Occup		11.	16b. Kind of	Business/In	dustry
215	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of v d)	working			
7	ed wil	Con	12		Self	Employed	l		Photo	graph	У
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle		ime)	
<u>y</u> a	ould Men Marke	မှ	Anselmo Yui				f	tina Cabi			2222
Jar	12 sh h and 7 is m raum		19a. Informant's Name/Relationship (Typ					Rural Route Numb Montgomer			
e,	1 and Health		Maria V. Yui / Wif		The second second	osition (Name of			y VIIIIa 20c. Location	-	
Baltimore,	Pages ment of I		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crei	natory or other pla Crematorium		gust 30, 2004			aryland
Balt	permit. Departimport any inj		21. Signature of Funeral Selvinge License	M0130	0.5 300	Name and Address bert A. Pu West Mont	ess of Facility mphrey Fu tgomery A	meral Home, venue, Rock	/Rockvill ville, M	le, Inc Jarylan	i 20850–2805
			23a. Part1. Ther the disease, or complice shock, or heart failure. List only one	ations that caused the de- e cause on each line.	ath. Do not ent	_		_			Approximate Interval Between
g	Physician		Immediate Cause (Final disease or condition	Hyper tens	renl	Cardia	o Vasent	In de	serse	ŀ	Onset and Death
	/Medical Examiner		resulting in death)	We to (or as a conse	equence of):					+	7
Н	Lxammer	-	Sequentially list conditions, b.	700000000000000000000000000000000000000							
	pei iist	Examiner	cause (Disease or injury	Directo (or as a conse	squence ory						
	al-tra	xar	that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):						
8760,	cate be executed physician and the burial-transit	dical									
687	ificate g phy as the	0	d.								
Вох	leath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	sc. If yes, outcome of preg		75			23d. D	ate of delive	ery
	that the death ed by the atte detached for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fe 4 Pregnant at time of 9 Unknown		Ectopic pregnancy Other (specify)	у		M	lonth	Day Year
<u>О</u> .	at the by the	hys y	9 🗆 Unknown					-			
Records, F	es be	d by Physician/M	Part II. Other significant conditions conf	ributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	V		ne cause of death?
00	s been s should	lete						24a. Was	an 24b.	. Were auto	psy findings available
Be	The lavate has	Completed							osy	prior to cor death?	npletion of cause of
Vital		e e	25. Was case referred to medical				26. Place of C	1 Yes Death Check on c	2/2 No	1 🗆 Yes	2 <b>0</b> No
	S D	ToB	examiner? 1 ☐ Yes 2 No	ospital: Inpatient 2[	☐ ER/Outpatier	nt 3 DOA Ott	200	g Home 5 ☐ Resi		her (Specifi	()
0	ing Ph After th Ineral		27. Manner of ○ ath 1 Natural 5 Pending	28a. ate of Injury (Month, Day Year)	28b. Time o	f 28c. Injur	y at	28d. Describe I			,
sio	Attending ir death. ector: After by the fune	cati	Accident investigation  3 Suicide 6 Could not be				Yes 2 □No		_		
Division of	s after of all Directed in by	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (S City or To	Street and Num vn, State)	iber or Rura	l Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 Certifying Physical (Check only one)	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, death	h occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ace, and due to the courred at the time.	cause(s) and m date and place	nanner as st , and due to	ated. the cause(s)
	within To the comple	Me	29b. Signature and title of certifier	al,		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
	-		* Anhill	X aufman	~/	D-	1397	1	8/2	7/1	14
	/		30. Name and a ress of person who co	p ed se of death (Ite	em 23à) (Type,	Print)	- ' '		1	10	1
		11	Robert L. Kaufmann	a, M.D. 300	West 9	th Street	Frede	rick, Man	ryland	21701	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature 4	Soork	1		-		
	Registi	al	AUG 3 0 200	4 /	~	LOS MAN CANA					

		•	For State Registrar	State of Maryl		tificate of D			g. No.?	2051.1
10			Decedent's Name (First, Middle, Last	)				2. Date of Death	1	3. Time of Death
	Physici /Medio		Frederick Willia		Sr			August	31 20°04	
	Examir	er	4a. Facility Name (If not institution, give		TI	4b. City, Town, or L			4c. County of De	
			Golden Crest Assi				inster	9. Date of Birth	1	
i.,	Funeral Director		5. Social Security Number 6. Se X	x 3x3M 2□F 7. Age (iii) 86	rs. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, Oct 01	1917	inthplace (State or Foreign Country) MD
			Usual Residence of Decedent							
	ylan how		10a. State 10b. County		City, Town or Lo	cation minster				10d. Inside City Limits
	Ba-1 s	Director	MD Carro	TT	west					1A Yes 2 No
	vith th	Dire	10e. Street and Number			10f. Zip Code	157	10	g. Citizen of What ( USA	Country?
	s 23	ra	68 Ralph Street	12. Was Decedent Ever	0118 123	Was Decedent of His		city Vas or No-	14. Race - An	nerican Indian
215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show digal Exand at must be rodified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1	f Yes, specify Cuban.  1 ☐ Yes 2 ☑ No	Mexican, Puerto I	Rican, etc.)	Black, Wh	
2-0	72 ho natur	eted	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupat kind of work done du	ion iring most of working	ng 1	6b. Kind of Busines	s/Industry
121	Atthin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		aborer			Condoleum	Industries
d 21	filed within Hygiene. Sther than sent, It a M		17. Father's Name (First, Middle, Last)		1 110		18. Mother's Name			· IIIdabolloo
lan		To Be	Unknown				Margare			
Maryland	12 should ba fited w h and Mental Hygiel f is marked other ti raumatic event, II.		19a. Informant's Name/Relationship (T			ng Address (Street an				Zip Code) .776
	is 1 and 2 should of Health and Meritem 27 is market other traumatic		Frederick W. Ziegl 20a, Method of Disposition		b. Place of Dispo				Oc. Location - City of	
Baltimore,	Page: nent o ant: If ury or		1 Surial 2 □ Cremation 3 □ 1  4 □ Donation 5 □ Other (Specify)	Removal from State	eadow Br	anch Cemet	ery 9/4/	2004 V	Vestminste	er, MD
Bal	permit. Departmine fimportal any inju		21. Signature of Funeral Service Licens	-/-	- 4	ricts fund 12 Washing	rton_Road	Westmi	inster, M	
8760,	Physician / Medical Examiner   bulk sician and   bulk sician and   s the parial-transit	ai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor Due to (or as a cor	isequence of):  Dark isequence of):  Chris	Infa	retim		Aulan	Onset and Death
687	ificate g phys	edicai		d						
O. Box	The taw requires that the death certific, its has been signed by the attending place 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
rds, P	quires that in signed b	þ	Part II, Other significant conditions co	entributing to death but not	resulting in the u	nderlying cause giver	n in Part I.			to the cause of death?  Probably 4 Dunknown
Records,	sician: The law requir certificate has been si rector, page 2 should	Completed						24a. Was an autopsy perform	prior to	
Vital	ysician: is certific director,	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only one		agusted
<b>†</b>	S (7) T	10	1 ☐ Yes 2 No	Hospital: 1   Inpatient	2 ER/Outpatier	nt 3□ DOA Dther	4 ☐ Nursing Hor	ne 5 🗆 Resider	nce 6 Other (Sp	ecity) Jermy
$\sim$			27. Manner of Death  1 Z Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	. Work?	,	28d. Describe how	w injury occurred	7
ח	ing Pl	6	Matural S Tending			M 1 □ Y	es 2 No			
sion (	After Fune	ication	2 Accident investigation 3 Suicide 6 Could not be		At home form at			Of Location /Str	ant and Number or	Pural Pouta Mumbar
Division of	After Fune	ertification	2 Accident investigation				2	28f. Location (Str. City or Town,	eet and Number or i State)	Rural Route Number,
Division	After Fune	edical Certification:	2 Accident 3 Suicide 4 Homicide Certifying Phy	28e. Place of Injury -	ecify) knowledge, deat	reet, factory, office	e, date and place, a	City or Town,	State) use(s) and manner	as stated.
Division	ftel ftel	Medical Certification	2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only Medicel Exam	28e. Place of Injury - building, etc. (Sp. ysicien: To the best of my inner: On the basis of examples of examples of the basis of examples of the basis of examples of the basis of examples of examples of the basis of the	necify) knowledge, deatl mination and/or in	reet, factory, office	e, date and place, a nion, death occurre	City or Town, and due to the ca ed at the time, da	State) use(s) and manner	as stated. ue to the cause(s)
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alter completely filled in by the fune		2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury - building, etc. (Sp. ysicien: To the best of my liner: On the basis of exar and manner stated.	necify) knowledge, death	h occurred at the time vestigation, in my opi	o, date and place, a nion, death occurre	City or Town, and due to the called at the time, da	State)  use(s) and manner te and place, and did. Date signed (Mo.	as stated. ue to the cause(s)

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registra 1-Certificate of Death Reg. No. Decedent's Name (First, Middle 2. Date of Death Month Day **Physician** 10:20 AM September 15, 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Birthplace (State or Foreign Country) last birthday) Security Number **Funeral** 1 □ M 2 🗑 F Months 20-18-9105 Director Masy. Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28e-f show treumatic event, the Medical Examiner must be notified at Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? Items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after ☐Yes 2 No 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced "naturel". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) Hygiene. Secondary (0-12) College (1-4or 5+) other 18. Mother's Name (First, Middle, Maiden Sumame, Father's Name (First, Middle, Last, Be Mental Is marked o 1MOND Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number Department of Health a Importent: If item 27 Is eny injury or other tre once. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License. 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of the List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gangrenous Small Intestine Due to (on's a consequence of): Physician Days disease or condition resulting in death) /Medical Examiner Artery Occusion Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Chronic Mesenters 3 years Due to (or as a consequence of) Physician/Medicai use as the IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 XNo 9 Unknown Day for Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ◯ No 24a. Was an cate has page 2 s certificate 1 ☐ Yes 2 XNo To the Hospitel or Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 2 1 ☐ Yes 2 XNo 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 Yes investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide hours after within 24 hours a dical 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar DHMH 17 Rev 1/200

29b. Signature and title of certifier

31. Date filed (A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

East

AT2438946-D7

University Parkway, Baltimore, MD

29d. Date signed (Month, Day, Year)

September 15,2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Physician BIACK EARL 0 10:36 DM 2004 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner oF MARYLAND MEDICAL SYSTEM BAltiMORE If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1X M 2□ F 55 Yrs. 212-56-3233 Director MARY/AND Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at BAltiMORE Yes 2□ No Funeral Director MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? W. PRATT USA 1315 21223 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Be Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) SHOREMAN LONG LPPL NO 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 ESTER WElls permit. Peges 1 and 2 should t. Department of Heelth end Ment. Important: If Item 27 is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BAlto. MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other). Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State ā BALTIMORE MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilify TRVIN PCARROLL FUNERAL HOME 1712 W. TRAH STREET 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CELL CARCINOMA LETASTATIC CU AMOUS Examiner Due to (or es a consequence of) Completed by Physician/Medical Examiner -CCO law requires thet the deeth certificate be executed as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last and Due to (or as e consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Xves 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? certificate has The 2 X No 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 22100 Inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA this eral Director: After thi filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier 29b. Signature eg title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) BIDENT 30. Name end address d erson who completed cause of death (Item 23e) (Type, Print)

Registrar **DHMH 16 Rev 6/95** 

State

MUDY

Alpha Brown 04-5925 AKG

92	5		For	State of Maryland	•		Mental Hy	giene		
			State Registrar		Certifica	te of Death	1	Reg. No.	29544	_
	Physicia		1. Decedent's Name (First, Middle, Last)	1 Bro	000		2. Date of Dea Month	Day Yea		м
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)	4b. Cit	r, Town, or Location of Death	Septem	Der 13, 2 4c. County of D	004 9:59P	_
			Johns Hopkins Hospi			imore		NIA		
	Funeral Director		5. Social Security Number  6. Sex  Control of the security Number  1 Usual Residence of Decedent	7. Age (In yrs. las	BYrs. If Und Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth	0, 1946 M	Birthplace (State or Foreig Country) Aryland	ign
	yland how		10a. State 10b. County		Town or Location				10d. Inside City Limit	
	Ba-f s	Director	MD NA	1301	ltimore				1 Dres 2 N	10
	72 hours after death with the Maryland neturel; or items 23e or 28e-f show dical Examinat must be notified at		451 N. Milto	n Ave.	10f. 2	ip Code 1/205		10g. Citizen of What	Country?	
	ems 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, /hite. etc.	
36	rs after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		2 No Specify:		Specify:	Black	
2-00	72 hours "neturel", dical Ex		15. Decedent's Edu (Specify only highest grade	cation	16a. Decedent's Us	ual Occupation ork done during most of wor	kina	16b. Kind of Busine	iss/Industry	
21215-0036	S 2 3	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)	Kii i g	Home		
d 2	e filed with Il Hygiene. other thei		17. Father's Name (First, Middle, Last)		11011111111	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)		
lan	should be ad Mental marked c	To Be	unk.			unk.				
Maryland	S Par S		19a. Informant's Name/Relationship (Ty		19b. Mailing Addre	ss (Street and Number or Ru	0 11-			
	1 and 2 Health tem 27	ij	20a. Method of Disposition	laughter miaw	ce of Disposition (N	enrose Ave	Balto.	20c. Location - City	or Town, State	
mor	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State Sacri	netery, crematory or Hear F	1 7	22-04	Dundalk,	mp	
Baltimore,	permit. Pages Department of Importent: If i eny injury or o		21. Signature of uneral 5, vice Licens			and Address of Facility	, , ,		alaas	9
	#Q E 2 9		Spary 1/ m	W	Gary	P. March Fl	1 270 F		Pass Balto.	JW.
	2 Db		23a. Palki. Entief the disease, or compli shock or heart failure. List only or Immediate Cause (Final disease or condition					rest,	Interval Between Onset and Death	
	Physician /Medical		disease of condition resulting in death)	Due to (or as a conseque		iovascular Di	sease			
	Examiner		Sequentially list conditions,							
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. En ar Under you Cause (Disease or injury	Due to (or as a conseque	nce of):					
Ć,	be executed sicien and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					
8760	ate be physicie the bur	dicai		d						
9	death certificate be executed e attending physicien and of for use as the burial-transit	/Med	IF FEMALE:	3c. If yes, outcome of pregnance	*V			and Day of	4.6	
Вох	Jeath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 Live birth 2 Fetal d 4 Pregnant at time of dea	eath 3 Ectopic			23d. Date of Month	Day Year	
P.O.		hysi	9 Unknown	9□ Unknown						
	es De	by	Part II. Other significant conditions cor	ntributing to death but not resulti	ing in the underlying	cause given in Part I.	23e. Did to	\ \	e to the cause of death?  Probably 4  Unknow	Α/n
Records,	v requir been si should	Completed					24a. Was			
Rec	The lav	dmo					autop	med? death	autopsy findings availab to completion of cause of 1? fes 2 \(\text{\subset}\) No	t
Vital		BeC	25. Was case referred to medical examiner?			26. Place of Dea	1 ☐ Yes ith <i>(Check only o</i>		95 2 140	
of V	Physicien: this certific ral director,	P_	1 ☑ Yes 2 ☐ No		P/Outpatient 3 ☐ [			ence 6 Other (S	pecify)	
ono		tion:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	8b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred		
Division	I or Attendil after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)			28f. Location (S City or Tow	treet and Number or	Rural Route Number,	
Ö	itel or A irs after rel Direct led in by	Cert	Tiomide	building, etc. (Specify)			Ony or You	n, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Medical	29a. Certifier 1 ☐ Certifying Physical (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurre n and/or investigatio	d at the time, date and place n, in my opinion, death occu	, and due to the or rred at the time, or	ause(s) and manner late and place, and c	as stated. due to the cause(s)	
	To the within (	Mec	29b. Signature and title of certifier	and mainer sidies.	A 2	9c. License number	- 2	29d. Date signed (Mo	onth, Day, Year)	
	, , , , = 0		Dervetter	clan m	of	O.C.M.E.	5	September	14, 2004	
	7		30. Name and address of person who co	ompleted cause of death (Item 2		lon - c:				
	Sta	ete.	31. Date filed (Month, Day, Year)	32. Pagistrar's Signatur	111 F	enn Street, I	Baltimor	e, Marylar	nd 21201	
	Regist		SEP 1 7 20		to die					

				. 10000	State of Marylar	nd / Department of H	lealth and Me		e	
				For Stata Registrar	<b>,</b>	Certificate of L		Reg. N	0001	2051.5
		Dhusisi		1. Decedent's Name (First, Middle, La.	st)		2	Date of Death Month D	ay Year	3. Time of Death
		Physici /Medic	al	Doris J. C	oles			9 12	0 004	12:30 M
		Examin	er	4a. Facility Name (If not institution, give	1/	4b. City, Town, or	Location of Death	4	c. County of Death	1
		Funeral		5. Social Security Number 6. S		last birthday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth (Month, Day, Yea		nplace (State or Foreign
		Director		217-20-3347	M 20 2	5 Yrs. Months Days	Hours Min.	01 10 19		aryland
		and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
		Maryli 1 eho	tor	md, NA	B	altimore				1 Yes 2 □ No
		r 28a	irec	10e. Street and Number	,	10f. Zip Code		10g. C	Citizen of What Cou	untry?
		23a c	ai D	1700 Edmor	ndson Ave	2 212	23		USA	
		er des Itama	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specii ın, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Amer Black, White	
	36	urs aft	by F	1 Never Married 2 Married  3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 20 No	Specify:		Specify:	CK
	21215-0036	within 72 hours after death with the Maryland ene. then "natural", or itema 23e or 28e-1 ehow he Maulcel Exercities fauet be melified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ducation	16a. Decedent's Usual Occupa (Give kind of work done of	ation	16b.	Kind of Business/li	ndustry
	21	ithin ne. hen	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	1)		11 ( 00	Ilaca tol
	2	e filed wall Hygiel other the	S	17. Father's Name (First, Middle, Last,	)	Nurse	18. Mother's Name (/	First, Middle, Maide	on Surname)	HOSPITAL
	an	Mental Mental arked o	To Be	151 1 - 7	CUS ST.		Sarah	Jacobs	Marca	(5
	Maryland	and and	-	19a. Informant's Name/Relationship (		19b. Mailing Address (Street a	and Number or Rural F	Route Number, City	or Town, State, Zi	ip Code)
		1 and 2 Health tom 27 l		Timothy Cole	S	_8222 Kilmor	4 cl. 50	vern, N	1d. 2/6	
	Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐	Tremoval nom State   //	Place of Disposition (Name of cemetery, crematory or other place	Dat	200.	Location - City or T	own, State
	Itim	Part and		11. Signat re of Funeral Service Licer		arrison fores	ss of Facility	- ou	ings IIII	115, Md.
	Ba	permit. Depertrimporte		I presto	Tuss	Joseph	L. RUSS	runera	Home	Md. 21216
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	th. Do not enter the mode of dying	g, such as cardiac or r		111101 6	Approximate Interval Between
		Pnysician		Immediate Cause (Finat disease or condition		Candin Sulmon a	my Pailie	re		Onset and Death
7		/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	1 (			
Ö		Examine	<u> </u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	Ch of lung				
10/01		uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		7				
7	ó	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a conse	quence of):				
	8760,	ate be hysici the bu	lical	•	d					
20	/9 ×	Physiclan: The law requires that the death certifical tris certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregr	ancv			22d Date of deli	
۵,	Вох	atten atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Fet 4☐Pregnant at time of	al death 3 Ectopic pregnancy			23d. Date of deliv Month	Day Year
30	P.O.	that the de ed by the detached	hyst	9 Unknown	9□ Unknown					
<u>ي</u>	S, F	es tha igned l	by P	Part II. Other significant conditions of	contributing to death but not re	sulting in the underlying cause give	en in Part I.			the cause of death?
-	ecord	w requir been si should	ted	17/0 Media Y	elect up (rel)	und		1 🗆 Yes	2 □ No 3 3 Pro	bably 4 Unknown
	Rec	e law has b	mpie	H/0 65080	yes Hne	rink		24a. Was an autopsy performed?	24b. Were aut prior to co	opsy findings available ompletion of cause of
5		iclan: The l certificate ha rector, page		OS Management to modified	•			1□ Yes 2 SN	lo 1 ☐ Yes	2 🗗 No
9	Vital	ysicla is certi directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	□ER/Outpatient 3□ DOA Othe	26. Place of Death (6 er: 4 ☐ Nursing Home		6 NOther (Spec	W Hospins
)	J Of	ding Phy h. After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Work	y at 286	d. Describe how inj		10470
S	sior	eatl or:	catic	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	n	M 1 🗀 '	Yes 2 □ No			
\$	Division	after d Direct	Certification;	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, factory, office ify)	28	City or Town, Sta	and Number or Rui ite)	ral Route Number,
<del>(</del>		spital tours a neral C				owledge, death occurred at the time				
		To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Example)	and mannor stated	ation and/or investigation, in my or			nd place, and due	to the cause(s)
		To t To t	Σ	29b. Signature and title of certifier	2 11	29c. License	e number	29d. D	ate signed (Month.	. Day, Year)
		1-		Y Yukad 1	1. Hayes,	00	02270	9	110/04	
		5			completed cause of death (Ite	29c. Licenson  D Com 23a) (Type, Print)  and en Aut, 33  pture  Aparlson	8LT0 140	21201		
		Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		-//		
		Regist	rar	SEP1 7 2004	Several E	pour				

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

December Name (First Kandle, Last)   December					State of Maryla		tificate of			Reg. No.2	ΩĮ,	2051.6
PLANTIAL PROPERTY OF PRINTING PARTY OF TWO P				1. Decedent's Name (First, Middle, Las	t)				2. Dete of De	ath	. 1	3. Time of Death
Tennal Director  Future Care Nursing Blow  Future Care Nursing Blow  Forture Care Nursing Blow  Some Secret				Dorothy	0.				09	11 2		11:20pm
Social Security Number   Size								•		1		
State   Part Sta						4 4444 4 1						
Document	E			251-26-2780	☐M 2527F	Yrs.			(Month, Da			
To Father's Name (First, Middle, Maidler Sumanie)    To Father's Name (First, Middle, Maidler Sumanie)		pu k		Usuel Residence of Decedent	10c 0	city. Town or Loc	cation				10	d Inside City Limits
To Father's Name (First, Middle, Maidler Sumanie)    To Father's Name (First, Middle, Maidler Sumanie)		Aanyla f sho	0								"	1 ☐ Yes 2 🂢 No
To Father's Name (First, Middle, Maidler Sumanie)    To Father's Name (First, Middle, Maidler Sumanie)		288-	rect		ore Ra	mualls				10g. Citizen of V	/hat Count	ry?
To Father's Name (First, Middle, Maidler Sumanie)    To Father's Name (First, Middle, Maidler Sumanie)		3a or	<u></u>	5412 Old Court	Poad		2	1133		11.5	. A .	
To Father's Name (First, Middle, Maidler Sumanie)    To Father's Name (First, Middle, Maidler Sumanie)		death	ner		12. Was Decedent Ever in	U,S. 13. V			pecify Yes or No		e - America	
To Father's Name (First, Middle, Maidler Sumanie)    To Father's Name (First, Middle, Maidler Sumanie)	320	urs efter If, or he	by Fu		1 ☐ Yes 2 ☐ No If Yes, Give				o r noun, oto.,			
To Father's Name (First, Middle, Maidler Sumanie)    To Father's Name (First, Middle, Maidler Sumanie)	9-0	2 hou	ted	15. Decedent's Ed	ucation	16e. Deced	ent's Usual Occu	ipation	kina	16b. Kind of Bu	siness/Ind	ustry
To Father's Name (First, Middle, Maidler Sumanie)    To Father's Name (First, Middle, Maidler Sumanie)	218	thin 7	ple						Kiiig	_		
Physician Medical Examiner    Medical Examiner   Me		ed wi	Con		na	I	lousewi		- AFI A AAT I			
Physician Medical Examiner    Medical Examiner   Me	and	ntal H ad oth	Be							Maiden Sumam	e)	
Physician Medical Examiner    Medical Examiner   Me	Ž	thould ad Me merk meric	۲			19b. Mailin	a Address (Stree			er, City or Town,	State, Zip	Code)
Physician Medical Examiner    Medical Examiner   Me	<b>∑</b>	od 2 s	ı				-					
Physician Medical Examiner    Medical Examiner   Me	ē,	f Head if Head if Head other		20a. Method of Disposition	20b.				T			vn, State
Physician Medical Examiner    Medical Examiner   Me	E	Page nent c int: if		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	-		1	9/14/	04 Arbu	tus	Md
Physician Medical Examiner    Medical Examiner   Me	alt	omit.		21. Signature of Funeral Service Licen		22	. Name and Add	ress of Facility	5 50.33 14 5			
Physician Medical Examiner    Medical Examiner   Me	ш	205 # 3	- 03	Vinette	To some	1 4:	300 Wab	oash Ave			Md	21215
Physician Medical Examiner    Page   Physician   Physician   Page   Ph		- 6		232 Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the decone cause on each line.	ath. Do not ente	er the mode of dy	ring, such es cardiac	or respiratory a	rrest,		Approximate Interval Between
Sequentially list conditions, it is a consequence of):    Sequentially list conditions, it is a consequence of):				Immediate Cause /Final	0 0011	. /.	4	[- ·/.			!	Onset and Death
Sequentially list conditions, it is a consequence of):    Sequentially list conditions, it is a consequence of):				disease or condition resulting in death)	a. Congest	uc F	Teart	1-accur	2		-	
Sequentially list conditions, it is a consequence of):    Sequentially list conditions, it is a consequence of):	χ	* ×	Jer		Careba	or as a conseq	uence of):	accide	ent		1	
DOOR TO COLUMN T		cuted	aml							<del></del>		
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DOOR TO COLUMN T	87	physic physic the b	dle	that initiated events		(or es a consequ	uence of):				1	
The state of the s		centifi Iding			d. 1+1 N							
The state of the s	B	etter 3 for u	clar	Port II. Other significant conditions or	entributing to double but not re	eulting in the ur	adarlyina agues e	iven in Part I	23h Did	tohacco use cor	atribute to	the cause of death?
The state of the s	0	t the d by the	hys	Dy coha sin		ssulling in the u	idenying cause g	prominran,		, ,		
The state of the s		s that gned I	by P	13/2007.9								
1   Yes   2   No   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   No   Yes   No   1   Yes   2   No   No   Yes   No   No   No   No   No   No   No   N	cord		leted						24a. Was perfo	an autopsy med?	ava	ilable prior to npletion of cause
25. Was cese referred to medical examiner?	Re	he lav e hes ege 2	dmo						10	Yes 21 No		
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yeer)  Sept., 16, 2004	ta	tificet tor, p						26. Place of Dea				
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yeer)  Sept., 16, 2004	<b>₹</b>	ysicis is cer direc	To E		Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA	ther: 4 Nursing H	lome 5 ☐ Resi	dence 6 □Oth	er (Specify	)
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yeer)  Sept., 16, 2004	o uo	ding Ph th. After th funerel	tlon:	1 Naturel 5 ☐ Pending					28d. Describe	how injury occur	ed	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yeer)  Sept., 16, 2004	Divisi	or Atter efter dea Director in by th	ertifica	3 Suicide 6 Could not be	286. Place of injury - At		eet, factory, office	9	28f. Location ( City or To	Street and Numb wn, State)	er or Rural	Route Number,
1 5 5 5 9 3 1 Sept , 16, 2009		Hospital 24 hours Funeral	dical C	(Check only 2 Medical Exam	iner: On the basis of examin	nowledge, death nation end/or inv	occurred at the restigation, in my	time, date and place opinion, death occu	o, and due to the arred at the time,	cause(s) and ma date and place,	nner as sta and due to	ited. the cause(s)
1 5 5 5 9 3 1 Sept , 16, 2009		o the vithin o the omple		· · · · · · · · · · · · · · · · · · ·	Marine States					29d. Date signe	Month, L	Day, Yeer)
		+ <b>≠</b> ⊢ ŏ	_	1 Solhum	MO		D	58459		Sept-	, 16,	2004
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SYED 2A1D1, MD 7445 A FURNACE BRANCH RD, GLEN BURNIE, MD 2106.	,	21		30. Name and address of person who	completed cause of death (Ite	em 23e) (Type, A Fu A	Print) 2 NACE	BRANCH				
State Registrar  31. Date filed (Month, Payry Year) 32. Registrar's Sanature				3/2	<b>A</b>		V	<u> </u>				

DHMH 16 Rev 6/95

CPM 04-05964 Michael Crawford

		For State Registrar	State of M	•	artment of Health and rtificate of Death	•	giene	
Physici /Medio		1. Decedent's Name (First, Middle, Michael	Last)	Cra	wford	2. Date of De Month		3. Time of Death 1 18:02 M
Examir	er	4a. Fecility Name (If not institution, University of Ma	ryland-Sho	ck Trauma	4b. City, Town, or Location of D Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number  220-04-1641  Usual Residence of Decedent	7. A	ge (In yrs. last birthday) 26 Yrs.	If Under 1 Year   If Under 24   Months   Days   Hours   N	Min. B. Date of Bir (Month, Ba	th 9. Birth Col.	place (State or Foreign untry) Yland
death with the Maryland ms 23s or 28s-f show rmart be rediffed at	tor	10a. State 10b. County NIA		Baltimor				10d. Inside City Limits 1 Yes 2 No
th with the 23a or 28s	al Director	10e. Street and Number 4300 White	Ave.		10f. Zip Code		10g. Citizen of What Cou	untry?
ъ ≗ ≝	by Funeral	11. Marital Status  1 □ Never Married 2 Marrie  3 □ Widowed 4 □ Divorced	12. Was Deceden Amed Forces d 1 Tyes 2 Fif Yes, Give Year or Dates	? No	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi 1 ☐ Yes 2 ☑ No Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Race - Amer Black, White	, etc.
"natur	Completed t	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education	16a. Dece	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/I	
2 should be filed within 72 h and Mental Hygiene. Is marked other then "natu	Be Com	17. Father's Name (First, Middle, La	ast)	War	ehouseman 18. Mother's	Name (First, Middle	Food Co	0
s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve	ပ္	Emest Crawford  19a. Informant's Name/Relationshi	(Type, Print)	Ta la la	ng Address (Street and Number of			ip Code)
S 1 and Heal		20a. Method of Disposition  1 Burial 2/D Cremation		20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Balto, mo	20c. Location - City or 1	
permit. Pages 1 a Department of Hes Importent: If item any injury or othe		4 □ Donation 5 □ Other (Special Service Li		2	Mem. Hark 9- 2. Name and Address of Facility by P. March FlH:		Arbutus, M	
Pnysician /Medical Examiner	niner	23a. Part / Enter the disease, of canonic shock or heart failure. List of Immediate Cause (Final disease of condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ener underrying Cause (Disease or injury)	a Due to (or a	s a consequence of):	nshot woun	,	rrest,	Approximate Interval Between Onset and Death
cate be executed physician and the burlat-transit	dlcal Examin	that initiated events resulting in death) Last	c.  Due to (or a	s a consequence of):				
nat the death certific d by the attending petached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specity)		23d. Date of deliv	very Day Year
w requires that the de been signed by the a should be detached t	by	Part II. Other significant condition	s contributing to death	but not resulting in the u	underlying cause given in Part I.		tobacco use contribute to Yes 2∰No 3□Pro	the cause of death?
ysicien: The law requires the secretificate has been signed frector, page 2 should be	Completed					24a. Was auto perfo	psy prior to commed? death?	opsy findings available ompletion of cause of
ding Phy n. After this funeral d	atlon: To Be	25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death  1 Natural 5 Pending investigations.	Hospital: 1 Inpai  28a. Date of In (Month, D	jury 28b. Time of Injury	nt 3 DOA Other: 4 Nursin	28d. Describe	one)  dence 6 □Other (Special Special	ify)
<b>2</b> 4 5 5	Certification:	3 ☐ Suicide 6 ☐ Could no 4 Might Homicide determin	t ho	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office	28f. Location (. City or Tot	Street and Number or Rui wn, State) 1300 blo Butimere w	scle of Wind
he Hospitel in 24 hours a he Funerel i pletely filled	edical	29a. Certifier 1☐ Certifying (Check only one) 2 ☑ Medicel E	Physicien: To the bes xeminer: On the basis and manner	of examination and/or in	th occurred at the time, date and provestigation, in my opinion, death of	lace, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within 2 To the complet	W	29b. Signature and title of certifier	miD.		29c. License number O.C.M.I	Ξ.	29d. Date signed (Month September 1	
4		30. Name and address of person w	m. D	death (Item 23a) (Type,	Penn Street, Ba	altimore,	Maryland 21	201
St Regist	ate rar	31. Date filed Morety, Day, Year)	32. Regis	trar's Signature	e e			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:35 PM Coulter rene 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LIFE GROUP ABUNDANT HOME If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min 128-14-5132 Director Usual Residence of Deceder with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic avent, the Madical Examinar must be notified at 10d. Inside City Limits 1 Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4253 STATES UNITED death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after ☐Yes 2 1100 Yes, Give 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 þ Specify: Specify: WHITE 3 Nidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PETER PATRICK JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KELLY DAVIS/DAUGHTER 4253 BRIGHT ELLICOTT CITY MD 21042 othar t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages . permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Fineral Service License 21. Signat 22. Name and Address of Facility
Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a. Part1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Thomknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ 6ther (Specify ☐ ROUD HOME 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: : After Injury at Work? To the Hospital or Attending 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

 $\checkmark$ 

29b. Signature and the of certifie

31. Date filed (Month, Day, Year)

L.

Poblete

SEP 1 7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11055

Little

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

10, 2004

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month ERNEST F. CLASTNG 7:30A 12.2004 SEPTEMBER 4c. County of Death BALTIMORE 4a. Facility Name (If not institution, give street and number) 9200 GEORGIA BELL DRIVE 4b. City, Town, or Location of Death PERRY HALL

9. Birthplace (State or Foreign

7. Age (In yrs. last birthday)

Examiner **Funeral** 

Director

**Physician** 

/Medical

5. Social Security Number

or items 23a or 28a-f show the Medical Examiner must be notified at natural Hygiene.

permit. Page Department o Important: If any injury or once. Pnysician /Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. P.O. signed b Division of Vital Records, certificate the Hospital or Attending Physician: After hours after death. Director: filled in by 24 hours a within 2

fited within 72 hours after death with the Maryland Completed by Funeral Director 9200 GEORGIA BELL DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TIM PLATE .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event. 17. Father's Name (First, Middle, Last) Be MARY ALFRED E. CLASING, SR. 19a. Informant's Name/Relationship (Type, Print) 9139 GLEN MILL ROAD ERNST CLASING/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9-15-2004 HOLLY HILL CEMETERY 21. Signature 1211 CHESACO AVENUE Immediate Cause (Final YIGR disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 1 ☐ Yes 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 1 ☐ Yes % No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Natural 2 Accident 5 Pending 1 🗌 Yes 2 □No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9-16-1916 1**X** M 2□ F 87 Yrs 213-07-7400 MARYLAND Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County PERRY HALL BALTIMORE 1 ☐ Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21128 14. Race - American Indian. Black, White, etc. WHITE 16b. Kind of Business/Industry BETHLEM STEEL 18. Mother's Name (First, Middle, Maiden Sumame) (NEIL) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9139 CT FN MTLL ROAD BALTIMORE, MD 21234 BALTIMORE, MD 20c. Location - City or Town, State MIDDLE RIVER, MARYLAND 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME ROSEDALE. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OBSTRUCTIVE Julmonany DISEASE 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ¶o 24a. Was an autopsy 2 No 26. Place of Death (Check only one) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) LONG CORNER ROAD WHITE HALL MD 2116

State Registrar Registrar's Signatu

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 14, September 2004 Bernard F. Crist /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A LOCH RAVEN NURSING CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 11, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2□ F Days Hours Months 81 Yrs. MD. 215-14-7830 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Healih and Mental Hyglene.
sem 27 is marked other than "naturel", or Items 23c or 28e-f show the recumatic event, the Mexical Examinar must be notilited at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 TyYes 2 □ No Director N/A BALTIMORE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 103 N. CURLEY ST. 21224 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INSPECTOR BALTIMORE CITY 8TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SOPHIA PIECZNSKI FRANK CRIST ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If item 27 is y or other tre 318 EAST TIMONIUM RD., TIMONIUM, MARYLAND 21093 CAROLYN SANDLER/DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages i Department of H Important: If ite eny injury or ot once. cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State ST. STANISLAUS CEM. 9/20/04 BALTIMORE, MARYLAND 1 4 ☐ Donation 5 ☐ Other (Specify) CAHRLES S. ZEILER & SON, INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician monary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit that the death certificate be executed and Due to (or as a consequence of): of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 34☐ No 24a. Was an has 24 No 2 **X** No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify, 1 Yes 2 WNo 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Director: After Division 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) September 15 2004 29b. Signature and title of certifiq 30. Name and address of person who completed cause of death (Hem 23an (Type, Print) 560 ( 20ch Pavan Blod, Ballinero, Fldegistrar's Signature 31. Date filed (Month State SEP 17 2004

DHMH 17 Rev 1/2001

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Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Nicholas C. Di Natale Month Year Physician 13:45PM SEPT 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 619 Dumwich Way Baltimore Essex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth July 21, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Funeral Months 1**X** M 2□ F Maryland 82 218-14-4883 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Madical Examinar must be notified at MD Baltimore 1 ☐ Yes 2 X No Essex Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 619 Dumwich Way 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Iten any injury or other freumetic event, the Muchael Examin XYes 2 ☐ No f Yes, Give 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifWhite à 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Procurement Officer 12th Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Politz Thomas DiNatale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas DiNatale / son 619 Dumwich Way Baltimore MD 21221 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ParkwoodCemetery 9/18/04 Baltimore MD A □ Donation 5 □ Other (Specify) 21. Signature-of Funeral Service License. 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or pemplications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner mellitus DiABetes Sequentially list conditions, it any, leading to in modals cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consultation of Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician for use as the buria Records, P.O. Box 68760, Physician/Medical as the l nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. EARCINOMA of LARYNX Squamous 1 Yes 2 No 3 Probably 4 Unknown CARCINOMA NON-SMALL Cell 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HYPERTENSION 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel within 24 hours a To the Funerel I 29a. Certifier V Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GREENE BALTMORE KASAMON 21201 31. Date filed (Month 1 7 2004 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

State Registrar DHMH 17 Rev 1/2001

SEP 17 2004

29b. Signature and title of certifier

30. Name and address of person

VAKIL

KHASHAYAR

31. Date filed (Month, Day, Year)

For State Registrar

TRAVMA CENTER SHOCK Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

29c. License number

16233

29d. Date signed (Month, Day, Year)

BALTIMORE, MD

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Yeer 4 M September James 13 Sool /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner RGEORGES Manor Silver Care Silver Spr If Under 1 Year If Under 24 Hrs. 6. Sex 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Min 12M 20F 8 1236209690 Director 10-12 2. 6 WASHINGTON DO Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 Pres 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 1976s 2 No 1 Yes. Give Year or Dates! 943-1946 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Ind Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White à Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be JNKN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau MARGARE HU mD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Bynat 2 Cremation 3 Removal from State \* 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Daugherty Family Funeral Home And Cremation Center, P.A. 21. Signatu 2601 Mountain Road - Pasadena, MD, 21122 Pert 1. Enter the disease, a complications that caused the shock, or heart failure. List only one cause on each line. nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) with Metastases **Physician** arcinoma /Medical Due to (or as a consequence of) Examiner neimer Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day . Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hibrillation this certificate tria 1 Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case reterred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) filled in by the tuneral 27. Manner of Death 28c. tnjury at Work? 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred Director: Alter 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 7 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Cecilia Frank DOD 9/16/04 7:25 am

			1 - State Registrar  1. Decedent's Name (First, Middle, Last,			rtifica <del>te c</del>	or Death	2. Date of D	eath		2 9 5 5 5 3. Time of Death
	Physici /Medi		· Cecelia	- Fr	ink _			Month 9	Day 16	Year 04	7:25 a M
	Examir		4a. Facility Name (If not institution, give a 2817 Roselawn Aver			4b. City, Town	n, or Location of Dea Baltimor		4c. C	ounty of Deat	th
	Funeral Director		213-16-6192	7. Age (In y	rs. last birthday 82 Yrs.	If Under 1 Ye Months Day			irth lay, Year) 1922	9. Birt Co Mar	hplace (State or Foreign unity) 'Y Land
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Limits
	Ba-f s	ctol	MD N/A	В	altimor	е		· · · · · · · · · · · · · · · · · · ·			1 Yes 2 No
	with the	Dire	10e. Street and Number 2817 Roselawn Aven	116		10f. Zip Cod	8			en of What Co ed Sta	
	daeth ms 23	nera		12. Was Decedent Ever in	U.S. 13:		of Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or N		I. Race - Ame	
21215-0036	ges 1 and 2 should be filad within 72 hours attar daeth with the Maryland it of Health and Mantat Hyglena.  If Itam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic evant, the Medical Exart Merrital by rotified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify C		rto Rican, etc.)		Black, White Specify: Whit	
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212	12 should ba filad within hand Manta! Hygiena. 7 Is marked othar than "reumatic evant, It. Med	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Cook	DO NOT USB TEL	1190)		повр	rearre	Y
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Ma	od 2 st lith and 27 Is n traun		19a. Informant's Name/Relationship (Ty) Mrs. Joan Falter/I	•			et and Number or A rn Avenue,				
ē,	permit. Pages 1 and 2 Department of Health ( Important: If Itam 27 I any injury or other tra once.		20a. Method of Disposition	206	. Place of Disp	osition (Name of		Date		ation - City or	
Ē	Pa ant ury		1 ☐ Burial 2 ☑ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	ake Crem		Sep 17 2004	Belts	sville,	MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	11 MO			dress of Facility On and Fur			tives	- 00/4-2
	405 6 9		23a. Part1. Enter the disease, or compli	cations that caused the de			en Pastur			ltimore	Approximate
	Physician		Immediate Cause (Final	ne cause on each line.	Settle Borlot on	9			irrest,		Interval Between Onset and Death
١	/Medical		disease or condition resulting in death)	Due to (or as a cons	equence f):	arler	y dise	ase			
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-	ted nsit	xaminer	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury	Due to (or as a cons	equence of):						
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68760	ficate be ex physician s the burial										
39 ×	ertifica ding ph	Med	IF FEMALE:	2-16							
.O. Box	The law requires that the death certificate be tie has been signed by the attending physicia page 2 should be detached for use as the but	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	∃Ectopic pregnar ∃ Other (specify)	ncy		23	d. Date of delive Month	very Day Year
S,	es that igned b	by PI	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	inderlying cause	given in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
ord	w require bean sig should b	ted	cerebrovascul	ar disea	se_			1 🗆	Yes 2 🗆	No 3 ₽Pro	bably 4 Dunknown
Records,	e law i has bu e 2 sh	Completed						24a. Was	psy	prior to co	opsy findings available ompletion of cause of
a		e Co	25. Was case referred to medical	-				1 ☐ Yes	ormed? 2 □ No	death? 1 ☐ Yes	2 No
Vital	Physician: this certific ral director,	O B	examiner?	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA	\thom	ath (Check only of dome 5 PResi		Tother (Speci	i6r)
n of	ding Phy h. After thi funeral	J : UC	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			197
Siol	eat or:	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 No				
Division	tal or Att rs after d al Direct ed in by I	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, offic	е	28f. Location (. City or Tox		Number or Rur	al Route Number,
	To the Hospital or within 24 hours after To the Funaral Dire completely filled in b	Medical	29a. Certifier 1	ician: To the best of my k ler: On the basis of exami- and manner stated.	nowledge, deatl nation and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) an date and pl	d manner as s ace, and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0	0	29c. Lice	nse number		29d. Date s	igned (Month,	Day, Year)
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2	181		30. Name and address of person who con	1		Print)			1	2	./
3	Sta	te	30. Name and address of person who con Lawrence J Sayl 31. Date filed (Month, Day, Year)	1	505 051	Print) ler Dr.	502 Tou	ison, 1	nd.	21209	4

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7:14 PM Dtember 10 500-4a. Facility Name (If not institution, give street and number, Town, or Location of Death 4c. County of Death altimore ge (In yrs last birthday) KINS Cit If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Hours Months Days 1 □ M 2 2 F 220 30 1197 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD1 Yes 2 No ALTIMIKE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 No 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ONESTIC RNATE Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SPENCER LOHIE COLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 5 WOOD HVE CT. DATO, MD 21244 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 9.11.04 BAUTIMORE, MARYLAND 1 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility VAUCHTY C. GREENE FONERIN HIME 4905 YORK KDAD BALTO, MD 21212 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastation terine disease or condition resulting in death) Due to (or as a consequence of): Orie to (x as discussequence of) 21 day Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? ibrillation 1 🗌 Yes 2 X No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2□No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

death certificate be executed burial-transit attending physician use as the for P.O. should be detached à Division of Vital Records, certificate has the funeral director, page 2 this After or Attending

after death Diractor: /

filled in by

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic evant, the Medical Examinar must be multiped at

72 hours after death

tould be filed within Mental Hygiene.

Pages 1 and 2 s ment of Health an Department of Health a Important: If itam 27 lg any injury or other trains

**Physician** 

/Medical

Examiner

Physician/Medical

Be Completed by

Certification: To

29a. Certifier

Examiner

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? examiner? Hospital: \( \sum\_{\text{Inpatient}} \) Inpatient 2 \( \sum\_{\text{ER/Outpatient}} \) 3 \( \sum\_{\text{OOA}} \) 28a. \( \sum\_{\text{Injury}} \) 28b. Time of Injury \( \text{Injury} \) \( \text{M} \) 27. Manner of Death 1 Natural 2 Accident investigation М 1 ☐ Yes 2 📉 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number RES-000 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person y SZYMANSKI

29d. Date signed (Month, Day, Year) tember

Baltimore Wolfe St WHOO MOSTIN 32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Griffiths 09 10 2004 6:10p. /Medical Margaret 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Randallstown
Under 1 Year If Under 24 Hrs Baltimore Northwest Hospital If Under 1 Year Months Days 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛱 F Yrs 219-06-8347 52 Director 52 1.3 Jamaica Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or itams 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No Waldorf MD Charles Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Ct. 11736 Torcello 20601 Jamaica Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify: ģ 3 Widowed 4 Divorced Black natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assitant Nursing Home 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any jury or other traumatic event 2008. Elizabeth E. Dean Walford A. Shelton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11736 Torcello Ct. Waldorf, Md 20601 e of Disposition (Name of Dispositi Carol Halstead-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ▼□Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 9/16/04 Druid Ridge Pikesville, Md Signature of Funeral S 22. Name and Address of Facility
March F/H West 1300 Wabash Ave, Baltimore, Md Pint. Enter the diseast, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Immediate Cause (Final disease or condition resulting in death) SILGIZ **Physician** /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC RENAL FAILURE 1 Yes 2 No 3 Probably 4 Inknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 DNo 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 6 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel L 29a. Certifier Securifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

TZ=WHTSON

29b. Signature and title of certifier

HOSPITAL 5401 OLD . Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

154357

MIRCEA TOJOR

COURT ROAD PANDALISTOWN

29d. Date signed (Month, Day, Year)

15

MA 21133

(EPTEMBER

			1- State of Maryland Registrar	/ Department of Health and Me Certificate of Death	ental Hygier	2001 20000
	Physici /Medio		1. Decadent's Name (First, Middle, Last)  5120184 GREEN		2. Date of Death	Oay Year 3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number)  Unity Memorical Isosop, follows:  5. Social Security Number 6. Sex 7. Age (In yrs. ias:  2/6 3 4 38 6 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	4b. City, Town, or Location of Death  BA HTMURE t birthday)   If Under 1 Year   If Under 24 Hrs.   8 Months Days Hours Min.	B. Date of Birth (Month, Day, Yea	4c. County of Death  9. Birthplace (State or Foreign
	D D	o.	Usual Residence of Decedent  10a. State 10b. County 10c. City, 1	Fown or Location	-ugust 9,77	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Entit activitial to notified at ance.	Funeral Director	10e. Street and Number  180 4 2 32 M 54x & F  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	10f. Zip Code  2/218  13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ric		Citizen of What Country?  U.S.A.  14. Race - American Indian, Black, White, etc.
5-0036	72 hours after "natural", or it	ρ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Specify: Black Kind of Business/Industry
ind 2121	be filed within ital Hygiene. Id other than 'event, the we	Be Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  17. Father's Name (First, Middle, Last)	Custodian 18. Mother's Name (1	Jo, First, Middle, Maide	hNS LEPKINS UNIVERSILY en Sumame)
, Maryland	and 2 should ealth and Men n 27 Is marke har traumatic	P.	19a. Informant's Name/Relationship (Type, Print)  PRISCILLA GREEN		Houte Number, City	0 2/218
Baltimore,	nit. Pages 1 partment of Hi cortant: If iter injury or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	pe of Disposition (Name of Petery, crematory or other place)  Life S Memorial 9/21/  22. Name and Address of Facility 8 EH:	104 B	Location - City or Town, State
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	1129 N. CAROline St BA	Homise MI	Approximate Interval Between Onset and Death
8760,	Physician /Medical bulkerial and bulkerial and stipe private transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conseque	Sundrome.	va·	
P.O. Box 68	death certif e attending ed for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal dead 4 □ Pregnant at time of dead 9 □ Unknown	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
	w requires that the de been signed by the s should be detached f	by	Part II. Other significent conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Onknown
al Records,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes a No
Division of Vital	ing Phys I. After this funeral dir	atlon: To Be		26. Place of Death (0 VOutpatient 3 □ DOA		
Divis	Hospital or Attending 14 hours after death, Funeral Director: Atte tely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)		City or Town, Sta	<u> </u>
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowle image of	edge, death occurred at the time, date and place, and n and/or investigation, in my opinion, death occurred  29c. License number	at the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)  Date signed (Month, Day, Year)
)	A.			MD AT2438946 E		
	Sta Regista		31. Date filed (Month, Day, Year)  SEP 1 7 2004  32. Agistrar's Signature	J MEMORIAL HOSPITA	L, BALTI	MORE, MA 21218

		1	For State Ragistrar		State of M	1arylan		partment of ertificate o			ental Hy	giene	0001	20550
	Physicia	n	1. Decedent's Name (Firs	t, Middle, Last) ELIZAI	BETH	GRUN	ER				2. Date of De Month			3. Time of Death
	/Medica Examine		Facility Name (If not in	stitution, give st	reet and number	SPIT	2	4b. City, Town	edo	18		4c.	County of Deal	more.
*	Funeral Director		5. Social Security Numbe 212-18-0153 Usual Residence of Dece	10	M 2 (X) 7. A	196 (In yrs. I	last birthday Yrs.	Months Day		ler 24 Hrs. s Min.	8. Date of Bi (Month, Da 6-22-	rth ay, <i>Year)</i> -1908	Co	thplace (State or Foreign puntry) ARYLAND
	Maryland -f show			County BALTIN	10RE	10c. City	, Town or I		ROSED	ALE				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	3a or 28a	Funeral Director	10e. Street and Number 1606 ROSEDA	LE HEIG	TS AVE	JUE		10f. Zip Code	21237			10g. Citi	izen of What Co	ountry?
36	hours after death with the Maryland tural", or Itams 23a or 28a-f show al Examinar must be molified at	by Funer	11. Marital Status 1 ☐ Never Married 3 3 ☒ Widowed 4 ☐ 0	2 Married	2. Was Deceder Armed Forces 1 Tyes 2 2 If Yes, Give Year or Dates	i? No	S. 13	. Was Decedent o If Yes, specify Co			cify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify:	erican Indian,
/ M&// Maryland 21215-0036	d within 72 hours after death with the Marylan jiene. In than "natural", or itams 23a or 28a-f show the Medical Examinat must be notified at	Completed by	15. [ (Specify on Elementary/Secondary	Decedent's Educity highest grade (0-12)	ation completed) College (1-4o	r 5+)	(Giv	edent's Usual Occ e kind of work don DO NOT use reti	ne during m red)	nost of workir	ng	16b. Ki	ind of Business	_ '
∭ Sand 2	ould be filed Mental Hygi arked other atic event, the	To Be Co	17. Father's Name (First, UNKNOWN	Middle, Last)	F	ROBINS	ON	HOMEMAN	18. Mo	other's Name MAGDAL	(First, Middle			
Mary	nd 2 sh utth and 27 is m r traum		19a. Informant's Name/F NANCY GRUN	Relationship (Typ ER/ GRAI	e, Print) NDDAUGH]	ER		iling Address (Stre EASTERN			MORE,		or Town, State, . 21221	Zip Code)
( Seltimore,	0 0 = =		20a. Method of Disposition 1 ☑XBurial 2 ☐ Cre 14 ☐ Donation 5 ☐	mation 3 Re	moval from Stat	a C	emetery, cr	position (Name of lematory or other p OF FAITH		1	ate 3-2004		ocation - City or	Town, State  MARYLAND
(5) Balti	permit. Pag Department Important: any injury c		21. Signature of Funeral	Service License				22. Name and Add		CVA	CH/ROS ROSEL	EDAL	E FUNER	AL HOME 237
	Physician /Medical Examiner	Iner	23a. Part1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition and the cause. Enter Underlying cause. Enter Underlying Cause (Disease or injury	ure. List only one	Due to (or a	ed the death line.	uence of):	nter the mode of d	ying, such	as cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
(68760,		Medical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	d.		as a consequ								
P.O. Box	the death certifica y the attending ph ched for use as th	Physician/Medical	23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 Ø No 9 ☐ Unknown	nant	c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	I death 3	Ectopic pregnal					23d. Date of de Month	livery Day Year
	w requires that the de been signed by the a should be detached to	ρ	Part II. Other significant	conditions conf	ributing to death	but not resu	ulting in the	underlying cause	given in Pa	urt f.			1	o the cause of death?
I Reco	The law requirate has been page 2 should	Completed									24a. Was auto perf 1 Yes		prior to death?	utopsy findings available completion of cause of 2 No
Division of Vital Records,	hysician: this certified al director.	To Be	25. Was case referred to examiner?  1 Yes 2 No  27. Manner of Death	Н	ospital: 1 💋 Inpa 28a. Date of In (Month, I		ER/Outpati 28b. Time Injury	of 28c. In	Other: 4 🗆	Nursing Hon	(Check only ne 5 Res 28d. Describe	idence	6 □Other (Spe	ocify)
Ojvisior	or Attending Fafter death. Director: After in by the funer.	Certification	2 Accident	Pending investigation Could not be determined	28e. Place of		ome, farm.		☐ Yes 2		28f. Location City or To			ural Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical Co				of examina		ath occurred at the investigation, in m						
	To the To the Comp	M	29b. Signature and title	of certifier	V.5	idhaye	M	.D - 29c. Lice	ense numbe	er B		29d. Dai	te signed (Moni	th, Day, Year)
	Star Registra	-	30. Name and address of the state of the sta	t person who con the mount of t	Sidhow P 32. Red 004	death (Item	Fro	e, Print)  NKlin  Shoule	Solv	ose 1	Orive	Bon	1timor	e, MV 2/237

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla		artment of F		•	giene		295	s n
	Physici	an	1. Decedent's Name (First, Middle, La	•				2. Date of De Month	Day	Year	3. Time of 547	
	/Medio	cal	4a. Facility Name (If not institution, giv	e street and number)		4b. City. Town, o	r Location of Dear	09	09	2004 County of Death	170	Q <sub>1</sub> M
	Exami	iei	Mercy Medical	Center		D. 11	ore			ltimore	City	
	Funeral		5. Social Security Number 6. S	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		'h	9 Rinthol	ace (State of try) Virgin	r Foreign
	Director		Usual Residence of Decedent					UAN ZOJI	925	West	virgir	11 a
	show	7	10a. State 10b. County		ity, Town or L					10	od. Inside Cit 1X\\Yes	•
	the M	Director	Maryland N/	Α	Baltim	OYE 10f. Zip Code			10a. Citiz	en of What Coun		
	th with 23e or	ai Di	600 Light St.	Apt. 324			230			USA	7	
	items	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (5 an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 1	4. Race - America Black, White, 6		
920	urs aft	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ XNo	Specify:			Specify: Whi	te	
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or items 23e or 28e-f ehow te Walfell Examilier: usi Le natified et	Completed	15. Decedent's E (Specify only highest gra		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	orking	16b. Kin	d of Business/Ind	ustry	
121	within iene. then	lduic	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>bo not us</i> e retired maker	d)			Househol	d	
מ סר	be filed tal Hygie d other evant, II	Be Co	17. Father's Name (First, Middle, Last	)	Home	illakei	18. Mother's Na	me (First, Middle,			<u> </u>	
Maryland	should be and Mental marked o	To	Unknown		aing		Unkno					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Modreal Exaculture, ust be notified at once.		19a. Informant's Name/Relationship (Heather League gra			<sub>ng Address (Street</sub> Washingt					Code)	
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition  1  Burial 2 XCremation 3	Removal from State	cemetery, cre-	osition (Name of matory or other plac		Date		cation - City or Tov	vn, State	
Itim	permit. Pag Department Important: I any injury c	10	* 4 □ Donation 5 □ Other (Specification Specification Spe	y) Me						ltimore,MD		
Ba	permi Depa Impo any is		Muschell Service 200	Hallerg	1)	2. Name and Addre	<sup>ss or Facility</sup> St tain Roa	allings <u>d Pasade</u>	Fune na Mi	ral Home D 21122	P.A.	
			23a. Part 1. Enter the disease, or cord shock, or heart failure. List only	plications that caused the dea one cause on each line	ath. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Hub K	quence of):	1						
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o,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a conse	quence of):	nul_1.V	PERKL	ye.				
8760,	icate be ex physician s the burial	dical		d					_			
Box 6	death certifice attending ph of for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy				2.	3d. Date of deliver	v	
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P.0	res that the de signed by the a be detached f		9 ☐ Unknown *  Part II. Dther significant conditions of		culting in the u	aderbina cauco aix	on in Bart I	23a Did to	shacco He	e contribute to the	anuso of de	nath?
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ed by	Tarrii. Bullot signinozii conditions	Shiributing to death but not re	sulling in the c	riderlying cause giv	en in raiti.		/es 2□		1/	nknown
eco	e law re has bee je 2 sho	Completed						24a. Was		24b. Were autop	sy findings a	vailable use of
a B	stcian: The certificate hir								med? 2□No	death?	2□ No	
Vital	ysiciar is certif directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	00	ath (Check only o		Other (Specify)		
n of	ding Phy h. After thi funeral c		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe h				
Division	r Attendii er death. rector: A by the fu	icatic	2 Accident investigation 3 Suicide 6 Could not b	1		M 1 🗆	Yes 2 □ No	006 11: /6	·	Musels and I		
DIVI	of or Al after of Direct	Certification:	4  Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, sti ify)	reet, factory, office		City or Tow	rn, State)	Number or Rural	Houte Numb	er,
	To the Hospital or Attending Physician: whith 24 hours after death or attending the Funeral Director: After this certification the Funeral Director. After this certification in the funeral director, the funeral director.	Medical C	29a. Certifier (Check only one)  Certifying Physics (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the curred at the time, c	ause(s) a	and manner as sta place, and due to t	ted. he cause(s)	
	To the To the comp	ž	29b. Signature and title of certifier	MD		29c. Licens	6   3   3	:		signed (Month, D	ay, Year)	
•	a		Pull leta	L IVIV	= 00c) C		01719		1/1	6/04		
			Kelly Datshu M	completed cause of death (Ite	301		nore, M	D 2126	)2			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 1 7 20	32. Agistrar's Sign		and .						

Please Type or Print in Black Indelible Ink Ensure All Co

.10 Mend	dez	Agullar For State Registrar AMEND ITEM	State of Maryland /			•	-	e. 
Physici /Medic		1. Decedent's Name (First, Middle, Last Rogelio Mendez Ag	")	) HERNADEZ →	GONZALEZ	. Date of Deat		3. Time of Death
Examir		4a. Facility Name (If not institution, give 1200 Bowie Road	street and number)	4b. City, Town, o	r Location of Death		4c. County of C	
Funeral Director		Social Security Number     6. Se	7. Age (In yrs. last bi		If Under 24 Hrs. 8 Hours Min. N	Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Forei Country) Mexico
a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge	10c. City, Tov					10d. Inside City Limi 1 XYes 2 □ N
3a or 28	Il Director	10e. Street and Number 14705 Bowie Rd. #1	04	10f. Zip Code 20707		10	Og. Citizen of Wha	•
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avent, the Medical Examinationals the notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	13. Was Decedent of H	lispanic Origin? (Speci an, Mexican, Puerto Ri Specity: Mexic		14. Race - A	American Indian, Vhite, etc. White
within 72 ho ene. than "natur re Medical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry	
filed w Hygier other tl		3 17. Father's Name (First, Middle, Last)	P	acker	18. Mother's Name (i	First, Middle, M		
Mental Mental arked c	To Be	Enrique Hernandez	Velasquez		Esperanza	Carbaja	al	
1 and 2 should Health and Men am 27 Is marke thar traumatic		19a. Informant's Name/Relationship (7 Gerardo Hernandez		o. Mailing Address (Street 705 Bowie Ro				
or = ro		20a. Method of Disposition  1 Burial 2 Cremation 3 1 1 2 Other (Specify,	Removal from State Pante C	of Disposition (Name of try, crematory or other place in Municipal Albino Cemet	Dat UW		20c. Location - City	or Town, State
permit. Page Department o Important: If any injury or once.		21. Signature of Juneral Service Licens		22. Name and Addre	ss of Facility Hine		ldi Funer	
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused the death. Do ne cause on each line. a	not enter the mode of dying				Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Earl of John in Cause (Disease or injury	b. Due to (or as a consequence	of):				
icate be executed physician and s the burial-transit	Ical	resulting in death) Last	C. Due to (or as a consequence	of):				
that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	a 3 □Ectopic pregnancy 5 □ Other (specify) _			23d. Date of Month	delivery Day Year
law requires that i as been signed by 2 should be deta	by	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did tob	4.0	e to the cause of death?  Probably 4 Unknow
The la ate has page 2	Completed					24a. Was an autopsy perform	/ prior ned? deat	e autopsy findings availat to completion of cause of 2? Yes 2 \( \subseteq \text{No} \)
Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3□ DOA Oth	26. Place of Death (0 er: 4 \sum Nursing Home			Specify) (SCCLE)
Attending or death. ector: After by the funer	Certification:	27. Manner of Death  1 Natural  Accident  3 Suicide  4 Homicide	Storth, Dey Year)	Time of larger 28c. Injury Wor 1   arm, street, factory, office	Yes 2 No	ctime	eet and Number or	by Track Rural Route Number,
To the Hospital or within 24 hours after To the Funaral Dir. completely filled in I	edical Cer	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exam	sician: To the best of my knowledg iner: On the basis of examination ar and manner stated.	e, death occurred at the tin ad/or investigation, in my o	ne, date and place, and pinion, death occurred	LOOF	use(s) and manner	r as stated. due to the cause(s)
To the within To the comple	Med	29b. Signature and title of certifier		29c. Licens O.C.M		(	d. Date signed (Me	onth, Day, Year) 25 • 2004

State

Registrar

SEP 1 7 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

# PATIENT KNOWN AS "MEDITH HAZEL"

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer 2209 **Physician** HTZQ isz 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE HOSPITAL CITY OF If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Days

Month, Days 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Year) **Funeral** Days 1981M 2□ F 220 76 3272 MARTLAND Director JAN.13 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or Items 23s or 28e-f show other traumatic event, the Mcdical Exams armust be notified at 1 ☐ Yes 2 No Director CARATAN SALTITORS BALLIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number BASO BAJ NATIONAL PIKS 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married 1 ☐ Yes 2X No Specify: Completed by BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SABLED 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LICAH CHARLES ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of BATIO MS. J. PAIL Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

22. Name and Address of Facility

22. Name Address of Facility SEPT 0 = 0 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 1 JARYLAND 4 □Donation 5 □ Other (Specify) FOREST  $H'\Pi$ uneral Strvice License ~ repaired and chimat 21. Signatul EPSIE. 1, Morrian Approximate interval Between Onset and Death 17 days 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 X No 3 Probably 4 □Unknown 1 🗌 Yes Mantal Retardadon, Schizophrenia, Squanous Cell Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an CARCINOMA of CRBIT, glavicina, anemia, soi zuro autopsy performed? Yes 2X No certificate has hypathyradism 1 ☐ Yes disorder, 25. Was case referred to medical examiner? Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28c. Injury at Work? 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Hospital or Attending PI
 24 hours after death.
 Funeral Director: After the Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sapt 12, 2004 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL OF BALTIMORE MD CATHECINE RE degistrar's Signatu 17 2004

Registrar DHMH 17 Rev 1/2001

State

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registra Certificate of Death 1. Decedent's Name (First, M 2. Date of Death ALTON ich ard 2:451 M SEPTEMBER 10 2004 4c. County of Death SMI MORE (ast birthday) Yrs. Year If Under 24 Hrs. 8. Date of Birth Month, Day Social Security Number Days Usual Residence of Decedent 10a. State 10b. County Town or Location HATTMORE 1 Yes 2 □ No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) GENERAL MOTOKS Elementary/Secondary (0-12) ASSEMBLER 17. Father's Name (First, Middle, Last) O HNSON WOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY JOHNSON DAVEHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation HARK 9.17.04 BALTIMORE, MARYLAND ^ 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN C. GREENE FUNERAL HOME 21. Signature of Funeral Service Licensee YORK ROAD BAUT MORE, MARY LAND 21212 June 23a. Part1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final XEARS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 21XNo 26. Place of Death (Check only one) Hospital: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

permit. Page Department of Important: If any injury or once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

in than "natural", or Items 23a or 28a-f show

other than

Pages 1 and 2 should be nent of Health and Mental ant: If item 27 Is marked o

Director

þ

Completed

with the Maryland

Baltimore, Maryland 21215-0036

as the burial-transit the attending physician and been signed by certificate has

this

Division of Vital Records, P.O. Box 68760.

Physician/Medical ģ Be Completed

Examiner

funeral director, page 2

Certification: To

The law requires that the death certificate be executed Hospital or Attending after death Director: filled in by 24 hours a

completely To the State Registrar

25. Was case referred to medical 1 ☐ Yes 2 No Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

Medical

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

St. Beltimore Md

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29c. License number 1024532 29d. Date signed (Month, Day, Year) September 15, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 KOMB 22 South GREEVE DAVID X VAN 31. Date filed (Month, Day, Year) SEP 1 7 2004 32. R

istrar's Signature

1		•	1 - For AMend Item 2&Unpend Item 23a, 27, 28a-I per me G840 Certificate of Death	ental Hygie 2-16-05	ne res No 101 29561
	Physician /Medical		1. Decedent's Name (First, Middle, Last)  DONTA MITCHELL JONES	2. Date of Death Month	Day Year 2004 11:03 A M
	Examir Funeral	er	4a. Facility Name (If not institution, give street and number)  Franklin Square Hospital  Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 24 Hrs.	8. Date of Birth	4c. County of Death  Baltimore  9. Birthplace (State or Foreign
7	Director		216 · 6598 1 M 2 F Yrs. Months Days Hours Min.  Usual Residence of Decedent  10a. State 10b. County 10c. €ity, Town or Location	APRIL 20	
	urs after death with the Marylan el', or Items 23e or 28e-f show Exenirer must be notified at	rector	MD  BATI MORE  10e. Street and Number  10f. Zip Code	10a.	1 ☐ Yes 2 MNo  Citizen of What Country?
	death with ms 23e or	Funeral Director	14 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe		U.S.A.  14. Race - American Indian,
9600		þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Black, Waite, etc.  Specify: BLACK
21215-0036	c * 32	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work kind of work done during most of working into the property of the proper	ng   16l	b. Kind of Business/Industry  INFAN+
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) M. JONES 18. Mother's Name NOS		S. TAYLOR
	ulth ar 27 is r treu			ESSEX	(,MD 21221
altimore,	oermit. Pages 1 ar Department of Hea Importent: If item any injury or othe once.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	04 BA	c. Location - City or Town, State  MT MORE, MARY LAND
Ba	permi Depa Impo any is		21. Signature of Funeral Service Licensee  22. Name and Address of Facility VAV  4905 YORK DAD  23a. Part1. Enter the disease, or symplications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	GHM C. G	ORE, MARY LAND 21212 Approximate
	Prrysician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease) or condition resulting in death)  a. Sudden Unexplained Death in Infancy  Due to (or as a consequence of):		Interval Batween Onset and Death
760,	Examiner sician and purial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unuerlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):		
P.O. Box 687	Attending Physicien: The law requires that the death certificate be executed riceath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[ Yes 2 \] No 9 \[ Unknown \] 23c. If yes, outcome of pregnancy 1 \[ Live birth 2 \] Fetal death 4 \[ Pregnant at time of death 9 \] Unknown 5 \[ Other (specify) \] 9 \[ Unknown \]		23d. Date of delivery Month Day Year
	quires that i n signed by uld be deta	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
al Records,	icien: The law require certificate has been si ector, page 2 should b	Completed		24a. Was an autopsy performed 1 IX Yes 2	
Division of Vital	utending Physicien: The death. ctor: After this certificate ha	Certification: To Be	27. Manner of Death  1 Natural 2 Accident investigation  28a. Date of Injury  Found th, Day Year)  9-8-04  28b. Time of Found thy Work?  1 1 Yes X No	ne 5 Residence 8d. Describe how i	
Divi	To the Hospitel or Attence within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide  determined  determined  building, etc. (Specify)  Scene	ssex, Md	nt and Number or Rural Route Number, citate) 1617 Dartford Apt.
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  1 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  2 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  2 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  2 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  2 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  2 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  3 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  4 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  4 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  4 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, a check only one)  4 ☐ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and the check of the check o	ed at the time, date	and place, and due to the cause(s)
	To To	4	29b. Signature and title of certifier  O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		Date signed (Month, Day, Year) otember 09, 2004
	C+	ate	Pamela E. Scruthall, MD 111 Penn Street, Balt	imore, Ma	aryland 21201
	Regist		SEP 1 7 2004 Sinere & Sports		

	T DINOR	1	State of Maryland / Department of Health and M.  1- State of Maryland / Department of Health and M.  23a.21.28a-f. per me G83  Certificate of Death	ental Hygi 5 9-29-(	ene 042tas	29565
1	Physici	an	Shirley Marie Bynum	2. Date of Death Month SEPT.	9, 2004 Year	3. Time of Death
	/Medi Examir		Shirley Marie Jacobs-Bynum  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	DEFT	4c. County of Death	1655 P <sup>M</sup>
C		•	3800 WEST BELVEDERE AVENUE APT.916 BALTIMORE CITY		1110	
52.5	Funeral Director		5. Social Security Number  6. Sex 1 Months Days Hours Min.  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Nonths Days Hours Min.  1 Months Days Hours Min.  1 Months Days Hours Min.	8. Date of Birth (Month, Day, 1	(ear) 9. Birthp Cour	lace (State or Foreign try) MD
	yland		10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
	Ba-f s	Director	MD NA Baltimore			XXYes 2 □ No
	deeth with the Maryland ms 23e or 28a-f show rmust be notified at		10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	try?
36	or Ita	Fune	8800 West Belvedere Ave Apt 916 21216  11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No Specify:	cify Yes or No- tican, etc.)	U . S . A .  14. Race - Americ Black, White,  Specify:	etc.
5-0036	8 8 44	ed by	YWidowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	14	Sb. Kind of Business/Inc	lack
215	_ × N	Completed	(Specify only highest grade completed)  (Give kind of work done during most of workin life. DO NOT use retired)  (Give kind of work done during most of workin life. DO NOT use retired)	9	D. King of Businessynk	lustry
Maryland 2121	shoutd be filed within and Mental Hygiene. marked other then "umatic event, I've Men	Con	12th grade 5+vrs Social Worker		Universit	ies
and		Be c	17. Father's Name (First, Middle, Last)  18. Mother's Name  19. To be a long of the second of the se		iden Sumame)	
ary.	d 2 shoutd th and Mer 7 Is marke traumatic	ည	John Jacobs  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural		City or Town, State, Zip	Code)
Ž	os 1 and 2 of Health a item 27 ls		Roxanne Burroughs-Daughter 3762 Bonview Ave, B	altimo	re, Md 2	1213
Baltimore,			20a. Method of Disposition 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		c. Location - City or To	wn, State
Ë	permit. Page Department Important: Ii any Injury o		' 4 Donation 5 Other (Specify)  21. Six tatul. of Funeral Service Licensee  22. Name and Address of Facility	.8/04 B	altimore,	Md
Ba	permit. I Departm Importar any Injur		Dun D. Kek March Ellian	(JZ0)	Waba	1.6 .
			23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arres	t,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition Narcotic and cocaine intoxication			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	118 13	ler	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	executed an and rial-transit	Examiner	Cause (Disease or injury that initiated events c.			
8760,	be exe		resulting in death) Last Due to (or as a consequence of):			
687	ficate physics the	edical	d			
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transi	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	ry Day Year
	es that igned by be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
ords	w require been sig should b	ted t		1 🗆 Yes	2 ☐ No 3 ☐ Proba	ıbly 4 ∏Unknown
Vital Records,	. a .	Completed		24a. Was an autopsy performe 1 ☐ Yes 2	d2 prior to con death?	sy findings available inpletion of cause of
<u>K</u>	Physiclen: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 🔀 Yes 2 🗆 No 1 🗀 Inpatient 2 🗆 EP/Outpatient 3 🗀 DOA 1		se 6 Other (Specify	AT SCENE
υot		<b>⊢</b> ↓	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28	e 5 Hesident		AI SCHIL
sior	att att	catio	2 ☐ Accident investigation Found Unknown M 1 ☐ Yes 2 ▼ No	Unknown		
Division	l or Atten after deat Director: in by the	Certification:	4 Homicide determined 289. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	If. Location (Stree City or Town,	st and 3800 or Wurai	Belvedere
	spitel	al Ce	Home  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place are the time.		timore, MD	nted.
	To the Hospitel or Atta within 24 hours after de To the Funerel Directo completely filled in by th	edical	(Check only one)  2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E	29d	Date signed (Month, D SEPT . 10 ,	2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street, Baltimore	, Maryla	and 21201	
	Sta Registr		SEP 1 7 2004  SEP 1 7 2004  32. Registrar's Signature  Aparks			

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** 3:10 PM September 14 2004 Lillian T. Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth (Month, Day, Year, Jan 5, 19 **Funeral** Days Months Min. 1 □ M 2 1 F Hours Yrs. 1918 86 Director 214-05-0123 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examinar roust by notified at 1 ☐ Yes 2 No Directo Maryland Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 4043 Old Federal Hill Road United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 22No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 ₩idowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other treumatic event, 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Myrtle Irene Holmes Robert G. Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L Steger - Daughter 4043 Old Federal Hill Rd. Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 Saurial 2 Cremation 3 □Removal from State Glen Haven Mem. Park 18, 2004 Glen Burnie, Maryland \* 4 □ Donation (5 □ Other (Specify) 21. Signature of Funeral Service Licensee Kirkley-Ruddick Funeral Home P.A. 21061 421 Crain Highway S.E. Glen Burnie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician asmun event 5 /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): bivision of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No the 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? certificate 2 1 No 1 Yes the Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D4768 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Man Kerikabwa 1 Caymond MD 5 Smite

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 1 7 2004

Sorcet

32. Pagistrar's Signature

			1 - State Registrar	State of Maryla	ind / Depa			Mental Hygi	•	20567
	Physici /Medic			KORES				2. Date of Death Month	Day Year	3. Time of Death  9:08 P. M
	Examin Funeral Director	er	241-40-0100	GENERAL	A 68 / rs. last birthday) Yrs.	COLUM	ar If Under 24 Hrs	8. Date of Birth	4c. County of Dea Hawar D Year) 9. Bir Co	
	h the Maryland r 28a-f ehow r roullise at	Director	Usual Residence of Decedent		City, Town or Lo		е	10	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes ※ No
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow or other treumatic event, the Medical Examinat must be notified at or other treumatic event, the Medical Examinat must be notified at	by Funeral	10566 Twin Rive  11. Marital Status  1 Never Married 2 Married  XXwidowed 4 Divorced	TS Road  12. Was Decedent Ever in Armed Forces?  1 □ Yes XX No If Yes, Give Year or Dates:	1	21044 Was Decedent of If Yes, specify O	of Hispanic Origin? (S Juban, Mexican, Puer		USA  14. Race - Ame Black, Whit	e, etc.
21215-0036	filed within 72 ho Hygiene. other then "natur ent, Ire Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life. Teac		cupation ne during most of wo tired)	rking	Sb. Kind of Business	(Industry
Maryland	2 should be filed and Mental Hygie is marked other eumatic event.	To Be (	17. Father's Name (First, Middle, Last)  Mike Yionoulis  19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Stre		me (First, Middle, Ma Sayani: ural Route Number, d	S	Zip Code)
	Pages 1 and 2 sinent of Health an int: If item 27 is inty or other treu		Steve Yionoulis  20a. Method of Disposition 1 Burial 2 X mation 3 R	20b	207 Place of Dispo	Cheste	ertown St	Date 20	aithersb Oc. Location - City or	20878 urg, MD Town, State
Baltimore,	permit. Page Department of Importent: If eny injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License     1 □ Donation 5 □ Other (Specify)		22	2. Name and Ad	w ı	tzke Fu	neral Ho	mes, Inc. MD 21045
	Physician /Medical Examiner	Examiner	if any, leading to immediate	Due to (or as a cons	equence of):  N 1 7 (5) equence of):	er the mode of o	dying, such as cardia	c or respiratory arres	<b>,</b>	Approximate interval Between Onset and Death  TOTALS  1000 DAYS
<ol><li>Box 68760,</li></ol>	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burlal-transit	Physician/Medicai Exar	resulting in death) Last	Due to (or as a consider of pregners)  3c. If yes, outcome of pregners by the pregnent at time of the	mancy etal death 3	Ectopic pregna			23d. Date of del Month	ivery Day Year
rds, P.O.	w requires that the desbeen signed by the a		Part II. Other significant conditions cor	tributing to death but not r	esulting in the u	nderlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
of Vital Records,	lcian: The law re certificate has be rector, page 2 shu	Completed by	HYPERTENSIO DINTICULITIE	N					prior to death? No 1 □ Yes	topsy findings available completion of cause of
	ding After fune	ation: To Be	27. Manner of Death  Natural 5 ☐ Pending  2 ☐ Accident investigation	ospital: Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	28c. Ir	26. Place of Dea Other: 4 Nursing H njury at Vork? Yes 2 No	ath (Check only one) dome 5 Residen 28d. Describe how	ce 6 □Other (Spe	cify)
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Special	cify)			City or Town,		
	To the Hospitei within 24 hours To the Funerei completely filled	Medical	(Check only one)  2 Medical Examin	ician: To the best of my k ter: On the basis of exami and manner stated.	nowledge, death	vestigation, in m	y opinion, death occu	irred at the time, date	se(s) and manner as e and place, and due	to the cause(s)
)	n = 3 + 8		30. Name and address of person who co		em 23a) (Type,	-	74	0,	9/12/2009	* * * * * * * * * * * * * * * * * * * *
	Sta Registi		DAVI D NY+NJOA 107 31. Date filed (Month, Day, Year) SEP 1 7 2004	mpleted cause of death (It	PATU X E	NI TAR	KW AY CO	LUM BIA M	n) 21049	_

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Deceded Name (First, Middle, Last) 2. Date of Death 3 Time of Death September, **Physician** 2000 ulh MC 3:28 PM 111 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne 205 Glen Pasadena Arundel Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/15/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Yrs. Director 85 GA 213-16-6112 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No Pasadena MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Itams 23a or 2 ury or other traumatic event, It's Madical Examinat must be not 205 Glen Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: Specify. 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman W. Platzke Esther M. Wallace ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD 21122 Patricia McNeice/Daughter 205 Glen Road, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. \* 4 □ Donation 5 □ Other (Specify) MD Veterans Cem 09/20/04 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Jul mora. no stane Chimic Obstructure Pnysician /Medical Due to (or as a consequence of): Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner sician and burial-transit so the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 X Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? this certificate 2 15 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 1 esidence 6 Other (Specify) P 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending 1 Natural investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide after within 24 hours a To the Funeral L 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cortific Medical 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 29c. License number pleted cause of death (Item 23a) (Type, Print) 0 3708 Mountain

DHMH 17 Rev 1/2001

State

Registrar

3 . Date filod (Month, Day, Year)

SEP 1 7 2004

32. Registrar's Signature

			For State Registrar	ate of Maryland	-	rtment of H		, ,	iene , No. 0 0 4	29569
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last)  Rebert By  4a. Facility Name (If not institution, give street	ANG Lipin	s/ci	4b. City, Town, or	Location of Death	2. Date of Dea Month SEpt.	Day Yea	4 6 25 PM
	Funeral Director	CI	Baltimore Rehabl. Fal.  5. Social Security Number  215-12-93 26  100 M	7. Age (In yrs. las	ay E st birthday) Yrs.	Baltin If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. E	Birthplace (State or Foreign Country) Maryland
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore		Town or Lo	cation erstown				10d. Inside City Limits 1 □ Yes 2 🛣 No
	ath with the 23e or 28 ust be no	Funerai Director	10e. Street and Number 116 Brunk Rd.			10f. Zip Code 2113	36	1	0g. Citizen of What	
9036	72 hours after death with the Maryland riatural', or Itams 23e or 28e-1 show diest Exendrat rust be notified at	þ	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. med Forces? (A)Yes 2 □ No Ves, Gwal 3 - 1945 ear orloates - 1945	1:	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc. Vhite
21215-0036	within ane. than	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)	npleted) college (1-4or 5+)	(Give life. [	ent's Usual Occupa kind of work done o OO NOT use retired, acher	luring most of work	ing	16b. Kind of Busine Educat	ŕ
Maryland	should be filed and Mental Hygid marked other umatic avant, II	To Be (	17. Father's Name (First, Middle, Last) Philip Lipinski				18. Mother's Name		O'Hara	
	fand 2 in the all the strategies that the strategies in the strate		19a. Informant's Name/Relationship (Type, F Mildred L. Lipinski 20a. Method of Disposition	- wife	116	g Address (Street a Brunk Rd.  Sition (Name of	Reister	stown, N	d. 21136	
Baltimore,	Page nent o ant: ff ury or		1 ☐ Surial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	., cen	land	Veterans	Cem. Sep	t. 22,20		Mills, Md.
Ba	permit. Departr importu any inji		23a. Part1. Enter the disease, or complication	ns that caused the death						Md. 21117
	Physician /Medical Examiner		shock, or heart failure. List only one ca Immediate Cause (Final disease or condition resulting in death)	use on each line.		rt D		_	est,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and he burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dreasas to injury that initiated events resulting in death) Last  d.	Due to (or as a conseque						
O. Box 6	The law requires that the death certifics the has been signed by the attending ptoage 2 should be detached for use as I	Physician/Med	in the past 12 months?	yes, outcome of pregnand □Live birth 2 □ Fetal d □ Pregnant at time of dea □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributions RENW Failur 6	ting to death but not result	ing in the ur	derlying cause give	n in Part I.		_	to the cause of death?  Probably 4 Information
Vital Records,		Completed	Diabets mellitu	s Coror	MANY	Artemy d	SEASE	24a. Was a autops perform	y prior t	
of	ing Phys	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospi  27. Manner of Death 1 Natural 5 Pending investigation	1 Minpatient 2 LE	R/Outpatien 8b. Time of Injury	28c. Injury Work	4 Li Itaraling Flo	me 5 Reside	e)  once 6 ①Other (S)  ow injury occurred	pecify)
Division	- 9	Certification:	3 Suicide 6 Could not be determined 28	Be. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospital of within 24 hours af To the Funaral Completely filled in	edicai	one) 2 Medical Examiner:	n: To the best of my knowl On the basis of examinatio and manner stated.	edge, death n and/or inv	estigation, in my op	inion, death occurr	and due to the ca ed at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
)	with Con	W	29b. Signature and title of certifier  Mann Mulica	in.D.		29c. License			9d. Date signed <i>(Mo</i>	
(	110		30. Name and address of person who comple	4 mp 390	3a) (Type, I	h-Raven	L Bouleva	of Bak	Sept. 16, timura Md	121218
	Sta Registi		31. Date filed (Mosth, Day, Year) 2004	32 Registrar's Signatur	Sign	ng		1,7	71.71	<u> </u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day ambdu /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Vumore If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country), **Funeral** Days Hours -48-8923 1 ☐ M 2 🕱 F Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Modical Examiner must be notified at 1 ☐ Yes 2 XNo Director Otimor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than? Elementary/Secondary (0-12) College (1-4or 5+) nsurance or other traumatic event, 17. Father's Name (First, Middle, Last) 18) Mother's Name (First, Middle, Maiden, Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trae 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 14 20c. Location - City or Town, State 20a. Method of Disposition 1 8 Burial 2 Gremation 3 Removal from State \* 4 ☐ Donation S ☐ Other (Specify) 2004 21. Signatur Funeral Service Licensee 22. Name and Address of Facility vans Chapel UKERAD once. 234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Kenal Cell Carcinoma Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco bee contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2. No 1 Yes To the Hospital or Attending Physician: pletely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 70 4 Nursing Home 5 ★ Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b, Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ONCO

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
SEP 1 7 2004

A COSCO N. CNO FLOS Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

D0056

Sep Kinber acou. 0720 AM 13 Esther May Mason 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 □ M 2 🕅 F Months Days 79 218-18-9587 30, Mar. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 ehow r then "naturel", or items 23e or 28e-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore MD Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 2nd Avenue 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes A No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1.2 should be filed within 7 h and Mental Hygiene.
7 ie marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: if item 27 ie marked other th any njury or other treumatic event, the once. 8 Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ George Warfield Florence Yingling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 112 2nd Avenue, Lansdowne, MD 21227 Patricia Kreitzburg Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 9-16-2004 Baltimore, MD 21. Signature of Fundral Service Livensee 22. Name and Address of Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Sepsis Days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Assistant Entrococcus Backremia Weeks Vancomucin Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sensequence of): Examiner the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Kespiratory Failure Weeks Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Prevmonia Weeks IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Gastraintestinal Disease, Hyperkntion 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed Anemica Sick Sinus Syndrame 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Bleeding Hip Arthroplasty 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L 1 Propertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 13,2004 P17008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death

3. Time of Death

State Registrar

Sylwich

31. Date filed (Month, Day, Year)

Kowpinski

ESTHE

900 caton the

32. Regigrar's Signature

Baltimore MD 21229

ΞŢ	Mazza	•	1 - For State Registrar	State of M	laryland	-	artment <i>tificate</i>				-	giene	100	2	9572	
	Physici	an	Decedent's Name (First, Middle, Last)      Decedent's Name (First, Middle, Last)  2. Date of Death Month Day											Time of Death		
	/Medic	al	Daniel R. M  4a. Facility Name (If not institution, give		-1		4h Cih. I	Tour or	Location of	of Dooth	Septem	mber 11, 2004 21:55 M				
4	Examin	er	Howard County Gene				,	olum		JI Death		40.	Howa			
	Funeral		5. Social Security Number 6. Se	x 7.A		ast birthday)	If Under	1 Year	If Under:		8. Date of Bir	th			(State or Foreign	
	Director		048-80-7667	MM 2□F	20	Yrs.	Months	Days	Hours	Min.	(Month, Da Jan. 2	27, 1	.984 Co	nnec	ticut	
	pu		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation							10d I	nside City Limits	
	daryië f sho	ō	MD Balti	more	,			. +							Yes 2∑No	
	28a-	Director	MD         Baltimore         Arbutus           10e. Street and Number         10f. Zip Code         10g. Citizen							zen of What (	en of What Country?					
	h with		922 Oakmoor Drive						2122	7		Uni	ted St	ates		
	ems ?	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Deced	ent of Hi			cify Yes or No Rican, etc.)		14. Race - An Black, Wh	nerican Ir		
36	s after	by Fu	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give		i	1 ☐ Yes 2		Specify:		,		Specify:	Whi	te	
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yla		<sup>L</sup>	Donald Mazza					/2			y Joan					
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Baltimore,			1 Burial 2 Cremation 3 D	Removal from State )	θ	ometery, crei view (	,		· 1	9_1	17-2004	R	altimo	ro	MD	
alti	permit, Page Department Importent: It any injury o	1	21. Signature of Funeral Service Licen	1		22	2. Name and	d Addres	s of Facility	Ambro	ose Fun	eral	Home.	Inc	•	
m	Per Ling		alline Sk	MODA	Ti.						Rd., A					
			23a. Part1. Enter the disease, or compitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death												erval Between	
	Physician	P	Immediate Cause (Final disease or condition resulting in death)	a/	nuitip	le Ti	yune.	5						Ons	set and Death	
	/Medical Examiner		Tesuling in dealing	Due to (or a	s a cons	uence of):	1)									
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	cuted id ansit	Examine														
ó	ate be executed thy sician and the burial-transit		resulting in death) Last	Due to (or a	s a consequ	uence of):										
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9	death certifics e attending ph ed for use as the	/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	nev							201 0-111	-1		
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s, P	The law requires that the tte has been signed by th bage 2 should be detache	by P	Part II. Other significant conditions co	ontributing to death	but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco u	se contribute	to the ca	use of death?	
ord	v require been sig should b					-					1 🗆 '	Yes 2	<b>A</b> No 3∏F	Probably	4 Unknown	
Record	e law r has be je 2 sh	Completed									24a. Was autor	osy	prior to	o comple	indings available tion of cause of	
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Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	.5		(Check only o					
of	Phys	T. To	1 XYes 2 No 27. Manner of Death	28a. Date of In		ER/Outpatier 28b. Time o		A Bc. Injury	4 🗆 140		ne 5 🗆 Resi			ecify)	, , ,	
on	ding F th. : After s funer	Certification:	1 □ Natural 5 □ Pending 2 ★ Accident investigation	(Month, D	lay Year)	9:10	PM	Work 1 □ `	? L	No É	perator o	f mol	viegele	MUVE	ved in	
Division	l or Attendi after death. Director: A lin by the fu	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I	_	me, farm, sti	eet, factory	, office		2	28f. Location (	Street an	d Number or F	Rural Roi	ute Number,	
Ö	tel or rs afte el Dir	Cert	4 Citionious	Danding, (	street					6	DZD Mars		5-d 5	ridge,	MD	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune	ical	(Check only Medical Exam		of examinat											
	thin 2 thin 2 the omplet	Medical	29b. Signature and title of certifier	and manner s	stated.	-	29c	. License	number			29d. Dat	e signed (Mor	nth, Day,	Year)	
	F ≯ F 8		Annek Gron	Hhall mi				0.	C.M.1	E.			ember			
•	0,		30. Name and address of person who		death (Item	1 23а) (Туре,	Print)					-epr	- INVOL	/		
	l		Pamela E. Southa	11, M.D.	0				reet,	Balt	imore,	Mar	yland :	2120	1	
	Sta Regist		31. Date filed (Month, Day Year) 1	7 2004 Regis	ar's Signa	ture &	Ann	N								

	Sta	ate	31. Date itled (Month, Day, Year)	ho completed cause of death (Ite	in 33a) (Type, Priet)	ler Burn	ne. p	n)· 2	1061.
)	To the within 2 To tha complete	M	29b. Signature and title of certifier	Som	<b>D</b> 4	nse number	85	ate signed (Month	C moll
	To the Hospital or At within 24 hours after of To tha Funeral Dirac completely filled in by	edical	29a. Certifier (Check only one) Certifying (Medical E	Physician: To the best of my kn xaminer: On the basis of examin- and manner stated.	nowledge, death occurred at the attorn and/or investigation, in my	time, date and place, at opinion, death occurre	nd due to the cause(s d at the time, date an	s) and manner as id place, and due	stated. to the cause(s)
Division of	tanding death. tor: After the fune	Certification: 7	27. Magner of Death   Natural   5   Pending investige   3   Suicide   4   Homicide   Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M 1 [28c. Injury M 1	ury at 2. ork?	8d. Describe how inju 8f. Location (Street a City or Town, Stat	ury occurred  nd Number or Ru	
	S S	To Be	examiner?  1 Yes 2 No	Hospital: Inpatient 2	□ER/Outpatient 3□ DOA O	26. Place of Death ther: 4 ☐ Nursing Hom	(Check only one) ne 5 ☐ Residence	6 ☐Other (Spec	eify)
Vital Records,	The lay ate has page 2	e Completed	25. Was case referred to medical			OC Plane of Doobh	24a. Was an autopsy performed? 1 Yes 2 No.	prior to death?	topsy findings available completion of cause of
ords,	requires een sign	eted by					Yes 2	2 □ No 3 □ Pro	obably 4 Unknown
P.0	that the ed by th detache		9 ☐ Unknown  Part II. Other significant condition	9□ Unknown s contributing to death but not re-	sulting in the underlying cause g	given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
. Box 6	ath certifi attending por for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3 ☐ Ectopic pregnan	су		23d. Date of deli Month	very Day Year
8760,	certificate be executed uding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consect	quence of):	è lung	disage	<b>-</b> •	
	/Medical Examiner	er	resulting in death)	b. Due to (or as a consec	quence of):				
	Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	omplications that caused the dea nty one cause on each line.	th. Do not enter the mode of dy	ying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
Balt	permit. Departr Importa any Inju		21. Signatur J w neral Service Li	Spisoon .	22. Name and Add	ress of Facility St Itain Road	allings Fu Pasadena N		ome P.A.
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	B Removal from State	Place of Disposition (Name of cemetery, crematory or other place) tro Crematory I	ace)		ocation - City or	
	1 and 2 sho Health and tem 27 Is ma		19a. Informant's Name/Relationshi		19b. Mailing Address (Stree	et and Number or Rural			(ip Code)
Maryland	should be find Mental Financked of	To Be		J. McCus	sker	Doris	(First, Middle, Maide, B. Ov	,	
1212	e filed within al Hygiene. I othar than "	Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Li	College (1-4or 5+)	Warehouse mar	1		A&P Supe	r Fresh
21215-0036	in 72 h	Completed	15. Decedent's (Specify only highest	grade completed)	16a. Decedent's Usual Occu (Give kind of work don- life. DO NOT use retir	upation e during most of workin ed)	16b. l	Kind of Business/	Industry
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itama 23e or 28e-f show any follury or other traumatic event, I've Medical Evantical most be notified at ance.	þ	11. Marital Status  1 □ Never Married 2 ☑ Marrie  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? d 1X Yes, 2 □ No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Spetban, Mexican, Puerto For Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
	23a or	Funeral Directo	1210 Valley Road		2112			USA	
	the Mar 28a-f si	ector	Maryland Anne A	Arundel Pa	asadena 10f. Zip Code		10a. C	itizen of What Co	1 □Yes 2 🖾 No
	nyland how		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Inside City Limits
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			North Arun  5. Social Security Number	del Hospita	last birthday) If Under 1 Yea	Burnie r If Under 24 Hrs.	8. Date of Birth	nne Ar	tunde/ hplace (State or Foreign
	/Medic Examin	al	Edward 4a. Facility Name (If not institution,	A .	McCusker  4b. City, Town,	or Location of Death	Cotembe	C /5 Lo	47:54, M.
	Physici	an	1. Decedent's Name (First, Middle,	Last)			2. Date of Death Month Da	av Year	3. Time of Death
			For State Registrar	State of Marylar	nd / Department of  Certificate of			0001	00000

EDWARD MCCUS/LER

			State of Maryland / Department of Health and Me	•	•
			1 - State of Waryland / Department of Health and Me  Certificate of Death	ntar mygier Reg. i	DOOL DOET!
	Physici	an	1. Decedent's Name (First, Middle Last)	Date of Death	3. Time of Death
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	Exami	ier	Maryland General Hasoital Baltimore City		or obtains or obtain
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (in yrs. last birthday) 1 Under 1 Year   fl Under 24 Hrs.   8	Date of Birth Wonth Day, Yes	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	1-2-4	6 Maryland
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Itams 23e or 28e-f show ther then "natural" or Itams 12e Indilled at	ō	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	r 28a-	by Funeral Director	10e. Street and Number 10f. Zip Code	10g. (	Citizen of What Country?
	ath with	ral D	813 Brooks Lave 2 21217		USA
	ter der	Fune	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.
9036	ours at	l by l	3 Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify:		Specify: Black
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212	filed with! Hygiene. ther then	Somp	Elementary/Secondary (0-12) Queurs Auditor	S	tote OF MD
	be file tal Hy ad othe	Be	17. Father's Name (First, Middle, Last)		
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	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic event, Ite Medical Experiment must be redilled at	-	Damond Ramsey (SON) BIB Brooks lave, Ac	+ 2, Ba	16,MD 21217
Baltimore,	Pages 1 nent of He int: If Itan iry or oth	15	20a. Method of Disposition (Name of cemetery, crematory or other place)  1 Suburial 2 Cremation 3 Removal from State	20c.	Location - City or Town, State
ıltir			21. Signature of Funeral Service Ucensee	10T Ba	Services)
Ba	permit. Departr Imports any inju		tought the wanth) variable to the 10. 20	Ralto	·MB 2/2/2
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or reshock, of heart failure. List only one cause on each line.	espiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Onset and Death
	Examiner		Due to (or as a consequence of):  Sequentially list conditions  b. Chronic Obstructive Pulmorary Disc	ase	
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
<u>.</u>	te be executed ysicien and e burial-transit	Examiner	that initiated events c.  The property of the control of the contr		
3760		cal	d		
89 x	The faw requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		
Box	death of attended for u	Iclan	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		23d. Date of delivery  Month Day Year
P.0	that the de led by the a detached	Phys	9 Unknown		
	signed d be d			23e. Did tobacco	use contribute to the cause of death?  2 \( \sum \) No \( 3 \super \) Probably \( 4 \sum \) Unknown
Records,	faw require as been sig 2 should b	olete	The state of the s	24a. Was an	24b. Were autopsy findings available
l Re	The fa	Completed by		autopsy performed? 1 ☐ Yes 2 ☑ ↑	prior to completion of cause of death?
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 26. Place of Death (C	heck only one)	
of	Phys this aldii	n: To	1 Unpatient 2 EH/Outpatient 3 DOA 4 Nursing Home	5 Residence . Describe how inj	
sion	Attending ir death. actor: After by the funer	atlo	1 🛣 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
_	To the Hospital or Attenc within 24 hours after death To the Funeral Diractor: completely filled in by the			due to the cause	s) and manner as stated.
	the Ho lin 24 I the Fu	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date a	nd place, and due to the cause(s)
1	5 th Con	2	29b. Signature and title of certifier 29c. License number 8 9 5 4 1	29d. D	ate signed (Month, Day, Year)
i	11		30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print)		112-01
	4		Robert Cella M.D. Yo Maryland General H	05 pital	
	Sta Registr		31. Date filed (Month, Day, Year)  SEP 17 2004  32. Registrar's Signature	1	
DH	MH 17 Rev 1/2	· .			
			ORIGINAL		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death unshin 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Months If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MAKYCAAD 5. Social Security Number Min. Days Hours 1 M 2 DEF Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Brille 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Vans Functed Chapel 4 □ Donation 5 □ Other (Specify) - AIP 22. Name and dress of Facility EVENS 21. Signature 1 Funeral Service Incensee FORESH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END ARILINSONS YLANS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 20 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/2KNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performetal 1 ☐ Yes 2 ☐ No 2/2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 15 trees 22 No Other: 4 Nursing Home 5 Residence

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

permit. Pages 1 Department of H Important: If ite any injury or ot once.

**Physician** /Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Completed by Funeral

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiener, and its fleme 23e or 28e-1 ehow with: if fleme 23e or 28e-1 ehow with: if the 23e or 28e-1 ehow must or other fraumatic event, the Medical Exercities must be rediffied at

Baltimore, Maryland 21215-0036

and attending physician use as the detached for the Signed pe been has page 2 filled in by the funeral director, this After within 24 hours after deat To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

Examiner Be Completed by Physician/Medical Certification: To

IF FEMALE:

1 Yes

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

death.

State Registrar

Medical

Hospital: 2 ER/Outpatient 1 Inpatient

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

and manner stated

MA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

3

3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

889

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

6 Other (Specify)

CARR

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

5 Pending investigation

6 □ Could not be

determined

			For	State of Ma	ryland /	•			Mental Hy	giene	Э	
			State Registrar			Cei	rtificate of L	Death		Reg. No	100	20576
	Physicia		Decedent's Name (First, Middle, La.	Catheri	ne M.	Me	ise		2. Date of De Month	Da	y Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv	street and number)	( )	1	4b. City, Town, or	Location of Dea		40	. County of Deat	h <sub>s</sub>
			Franklin Sol	7	351170	4	15050	9016			Bolt	MALE
	Funeral Director		5. Social Security Number 216 – 28 – 2158	ex 7. Age □M 2□XF	(In yrs. last b	Yrs.	Months Days	If Under 24 Hrs Hours Min		rth ay, Year, 1,1	9. Birt 913 MA	hplace (State or Foreign untry) ryland
	pu »		Usuel Residence of Decedent  10a. State 10b. County		10c. City, To	um or Lo	ocation					10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f show	ō	MD Baltin	nore			Essex					1 ☐ Yes 2 XNo
	r 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Co	untry?
	th with	alD	5 Brett Court					21221		U	SA	
	ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	Specify Yes or Note (Note )	0-	14. Race - Ame Black, White	
30	d within 72 hours after death with the Marylan jiane. r than "natural", or Items 23a or 28a-f show then "natural", or Items 23a or 28a-f show the Maryland Exam net must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> N If Yes, Give Year or Dates:	lo	-	1□Yes 2□No	Specify:			Specify:Wh:	
9500-61212	72 ho	Completed	15. Decedent's E	ducation ade completed)	16	a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	nkina	16b. H	(ind of Business/	Industry
7	within ne. han *	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use retired Omemake:		3	0'	wn home	9
-	H H H		7Yrs  17. Father's Name (First, Middle, Last	)					me (First, Middle	e, Maidei	n Sumame)	
yland	should be marked o	To Be	Adolph Robl						Wise			
Mary	2 should and Men Is marks aumatic	_	19a. Informant's Name/Relationship (			b. Maili	ng Address (Street a	and Number or R	ural Route Numb	ber, City	or Town, State, 2	Zip Code)
	1 and 2 Health tem 27 l		Catherine Bowe	er/daught			0Berryma	nsLane				
920	Pages 1 nent of H int: If Itel iry or oth		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐		ceme!	of Dispo ery, crea La w	osition (Name of matory or other plac ncemeter	9/	17/04		ocation - City or ltimore	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic once.		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice)		Jun	O.T.	2. Name and Addres	a of Canilles				
n E	Depa Impo any i		1 R. Turn	Lonn	elly		300 Ma	ace Ave	. Balt	imo	neralHo re MD 2	omeofEssex 21221
			23a. Part1. Enter the disease, or per shock, or heart failure. List only	olications that caused one cause on each lin	the death. $\psi$	o not en	ter the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a SePSIS								Onsot and Douth
	Examiner		1	Due to (or as a								
Į.		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequenc	_						
	cuted nd ranslt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
Ď,	cate be executed physician and the burial-translt	i Ex	resulting in death) Last	Due to (or as a	a consequenc	e of):						
8760	physic	dicai		_ d								
Box	certif nding use at	υ/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of del	iverv
	death e atte	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1☐Live birth 4☐Pregnant at			⊒Ectopic pregnancy ⊒ Other (s <i>pecify</i> )				Month	Day Year
<u>о</u>	at the by th stache	hys	9 ☐ Unknown	9□ Unknown								
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions	contributing to death bu	ut not resulting	j in the u	inderlying cause give	en in Part I.			_1	othe cause of death?  obably 4 □Unknown
ö	v requir been s should	eted	110 St-1- 110	or refer		P 4						
Division of Vital Records,	ne law s has l ge 2 s	Completed by	C102111919	CVUITE	1611.	τ. ζ	-011715			opsy formed?	prior to death?	topsy findings available completion of cause of
ta	in: Th		25. Was case referred to medical					26 Place of De	1 ☐ Yes eath (Check only	2/C N	o 1 ☐ Yes	2 No
2	ysicle is cert direct	To Be	examiner? 1 Tes 2 No	Hospital:	nt 2 ER/	Outpatie	nt 3 DOA Oth	0.0			6 ☐ Other (Spe	cify)
0 _	ng Ph fter th		27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	y Year) 28b	. Time o	of 28c. Injun World	y at k?	28d. Describe	how inju	ıry occurred	
<u>S</u>	tendi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not to	00	At home			Yes 2 □No	204 Logation	/Ctroat a	and Alexander as Di	and Courts the sector
<u>&gt;</u>	aftar d aftar d Direc d in by	Certification;	4 Homicide determined		c. (Specify)	rarm, st	reet, factory, office		City or To			ural Route Number,
	To the Hospital or Attending Physiclan: The law within 24 hours aftar death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of	examination:	lge, dea and/or in	th occurred at the tim	ne, date and place pinion, death occ	e, and due to the curred at the time	e cause(:	s) and manner as nd place, and due	stated. to the cause(s)
	o the rithin 2 o the omple	Med	one) 29b. Signature and title of certifier	and manner sta	1180.		29c. Licens	e number		29d. D	ate signed (Monti	h, Day, Year)
	F 5 F 0	2	> anderha	lu, M	D, Phi	D				9	11610	, 4
ſ	10		30. Name and address of person who	completed cause of d	eath (Item 23a	а) (Туре	, Print)	1 1		q		
V	() `			13 1 9 600 F	ro-rik	lin	39 Ra 11	2011	e Balt	LIVE	ore, MI	2.13.37
	Sta Registi		31. Date filed (Month, Day, Year) SEP 1 7		ar's Signature	X A	from					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** BERNICE ANN MACHOVEC /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MERCY HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT . 1, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🕏 F 69 Yrs 215-30-2454 Director MD. Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 U.S.A. 424 LEHIGH STREET 21224 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married ō 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE 3 Widowed 4 Divorced \*natural'. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than °r Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 6TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ORVILLE T. BROWN ANNIE ELIZABETH HARTMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34953 19a. Informant's Name/Relationship (Type, Print) Important: If Item 27 Is any injury or other traus Pages 1 and 2 s ment of Health an 311 SOUTHWEST BUZBY CT., PORT ST. LUCY, FLORIDA MARK TUSSING/SON 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 9/20/04 LAUREL, MARYLAND 22. Name and Address of Facility CHARLES S. 21. Signature of Funeral Service Licensee ZEILER & SON. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Parti. Enter the disease, or complications transcaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sholk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final かくせいかれずる 10100 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Causa (Disease or that initiated events use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 Natural investigation after death Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral E 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who combeted cause of death (Item 23a) (Type, Print) SI 31. Date filed (Month, Day, Year) State SEP 1 7 2004

Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylar		ent of Health and ate of Death		giene Reg. No. 1	11. 0	0570
102	No. of the	18	1. Decedent's Name (First, Middle, Lest)			-	2. Date of Dea	ath C	3.	Time of Death
	Physicia		Martin	Nwaka			Month Septemb	er 2 2	Year 004 7	:45
	/Medica Examine	126	4a Facility Name (If not institution, give s	treet end number)		4b. City, Town, or	r Location of Death			• 7.7
1.78 5	Examme	; I	Belpre Health & Re			C ± 1	Condo			
10.3	Funcion	4.9	5. Social Security Number 6. Sex		. last birthday) If U	nder 1 Year   If Under 24 Hr	Spring s. 8. Date of Birt	h	ntgomer	y (State or Foreign
	Funeral Director			M 2□F 34	Yrs. Mon	ths Days Hours Mir		1970	Country) Nigeria	
10.0		-	Usual Residence of Decedent				1 13	1770	MIRCII	1
ou a	A N		10a. State 10b. County	10c. C	ity, Town or Location				10d. Ir	nside City Limits
M	100	ō	MD Prince Ge	eorge's	Landove	r			ţ	Yes 2□ No
4	288	i e	10e. Street and Number		10f	. Zip Code		10g. Citizen of V	What Country?	
3	3a o		6501 Landover Ro	oad		20785		U.S.A.		
d 21215-0020 filed within 72 bours effect death with the Mandand	is faint and Mental Hygiene. If health and Mental Hygiene. Itam 27 is merked other then "natural", or items 23s or 28s-f show other traumatic evant, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	2. Was Decedent Ever in U	J,S. 13. Was D	ecedent of Hispanic Origin? ( specify Cuban, Mexican, Pue	Specify Yes or No-	14. Rac	e - American In	idian,
_ #	in the state of th	호	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No			erto Rican, etc.)	Blac	k, White, etc.	
3	0,1	۾	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Y€	es 21 No Specify:		Specify	. U.S.	Α.
9 8	atura (	Completed by	15. Decedent's Educ		16a. Decedent's	Usual Occupation		16b. Kind of Bu	usiness/Industr	у
21215-0020	u Day	be	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind o life. DO NO	f work done during most of w T use retired)	orking			
7	Hygiene.	티	12th	College (1-401 5+)	Electric	ian		Priv	vate	
ם	Hyg othe	Be C	17. Father's Name (First, Middle, Last)		4	18. Mother's Na	ame (First, Middle,	Maiden Suman	ne)	
<u>a</u>	enta kad c ev	To B	Paul Nwaka			Helen	Nwaka			
7	and Mental Is marked of	-	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailing Add	Iress (Street and Number or F	Rural Route Numbe	er, City or Town,	State, Zip Cod	(e)
ž Š	Ith all		Theodore Osuala/I		7878 Joh	nson Avenue L	anham, Ma	arvland	20706	
ā, -	nent of Health ant: If Itam 27 is ury or other tra	-	20a. Method of Disposition	20b.	Place of Disposition	(Name of	Date	20c. Location -		State
OL S			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crematory		10 100 101			
# # # # # # # # # # # # # # # # # # #	Department of important: If any Injury or once.	-	4 Donation 5 Other (Specify)		HURCH CEME		10/02/04 J. B. Jen			
Baltimore, Maryland	mpo any l		21. Signature of Funeral Service License							
	10.2 % 0		3a. Part1. Enter the Reease, or complice shock, or heart failure. List only on			Landover Road		•	land 20	785
	g physician and as the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Lung Can	ory Failur for as a consequence cer With F for as a consequence	of): Brain Metastas	sis			
9/2	ysici	edica	that initiated events	Due to (	or as a consequence	of):				
89	as th		resulting in death) Last	Ì		•			i I	
Box	attending I	2	d.							
<b>a</b>	d for	Physician/M	Part II. Other significant conditions cont	tributing to death but not re	sulting in the underlyi	ng cause given in Part I.	23b. Did t	obecco use co	ntribute to the	ceuse of deeth?
P.0	ed by the a	À A			,-			Yes 2□ No		
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Vital Records, P.O. Box	s been signed I	Completed						an autopsy rmed?	availabi	utopsy findings le prior to tion of cause n?
جٌ عُ	te has	E					101	las 2½ No	1 □ Yes	s 2 <del>∏</del> No
		0	25. Was case referred to medical			26. Place of De	eath (Check only o		1	A
of Vita	direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐	BER/Outpatient 3	Other:	Home 5 ☐ Resid	1,5	er (Snecify)	
o å	rthis		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury et Work?	-	now injury occur		
o a	fundamental in	ᅙ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
Division	after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec		ctory, office	28f. Location (S City or Tou	Street and Numb vn, State)	er or Rural Rou	ite Number,
9	To transpland or Adenturing Firsy within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral d	edical C	29a. Certifying Physic (Check only one)	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death occur ation end/or investiga	red at the time, date and plac tion, in my opinion, death occ	ce, and due to the courred at the time,	cause(s) and ma date and place, a	inner as stated and due to the	cause(s)
4	Vithir Some	Me	29b. Signature and title of certifier	0		29c. License number		29d. Date signer		
. '	> - 0		( ) a 4 50 /	Insu.	11.6)	D4553	3	9-	4-0	4
R	7	-	30. Name and address of person who con	moleted cause of death (te	m 23a) (Type Driet)	0,700				•
	IJ		Daniel Snow M.D.			Circle Germa	ntown. Ma	aryland	20874	
انو	Stat					•		•		
	Stat	e	31. Date filed (Mastery, Year) 2004	Marie 1	C ASSOCI					

DHMH 16 Rev 6/95

		,	For State of M	aryland / Depa	artment of H			iene	04	29579
	Physicia		Decedent's Name (First, Middle, Last)     KATHLEEN     NANCE				2. Date of Deat Month SepT	Day	Year 2-004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number, 420 S. LEHIGH STREET		BAI	Location of Death		4c. Count	y of Death N/A	
	Funeral Director		402-50-7990 1□M XXF	ge (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 5-15-19	)33	9. Birthp Coun KEN	lace (State or Foreign try) TUCKY
	Maryland f show	lor	Usual Residence of Decedent   10a. State   10b. County   N/A	10c. City, Town or Lo		LTIMORE			11	0d. Inside City Limits 1)∑Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show Final be notiling at	Funeral Director	10e. Street and Number 420 S. LEHIGH STREET		10f. Zip Code	L224	10	Og. Citizen of	What Coun	try?
Ç	ja 💆 🚆	by Funera	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Armed Forces'  1 □ Yes 2 ☒ If Yes, Give Year or Dates:	No I	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 🌠 No		ecify Yes or No- Rican, etc.)		ce - Americack, White, e	
	Baltimore, Maryland 21213-UU36 permit. Pages 1 and 2 should be filed within 72 hours aff Department of Health and Mental hygiene. mportent: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Modical Exerci-	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	5+) (Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ition luring most of working	ng	16b. Kind of E	Business/Inc	lustry
	land 2	To Be Co	17. Father's Name (First, Middle, Last)  JAKE DINGUS	WF	AITRESS	18. Mother's Name EDNA	(First, Middle, M	Maiden Suma	TAURA me)	NT
	Mary alth and M 27 is mai		19a. Informant's Name/Relationship (Type, Print) DAVID NANCE/ SON		ng Address (Street a			City or Town		Code) 1224
	MOTE, Pages 1 and the part of He part of He part of He part of He part or other parts or other p		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	1	sition (Name of matory or other place LL CEMETER	9)		20c. Location		
	Balti permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	12	2. Name and Addres	s of Facility CVA				
	OX 68/60, certificate be executed Medical Examination and uding physician and use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mixtated events cause.	d the death. Do not entine.  a consequence of):  a consequence of):		y du				Approximate Interval Between Onset and Death
	ox 6 certific nding p	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  d.  23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	ry Day Year
4	<b>6</b> 8 8 <b>0</b>	þ	Part II. Other significant conditions contributing to death I	out not resulting in the u	nderlying cause give	n in Part I.		acco use con	tribute to the	e cause of death?
67	The The page	Completed		•			24a. Was ar autopsy perform 1 🗆 Yes 2	/	prior to con death?	sy findings available pletion of cause of
	Division of Vital R To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Certification; To Be	27. Manner of Death  1 Splatural 2 Accident investigation investigation  5 Could not be	ay Year) Injury	M 1 Y	at 2 ? 'es 2 □ No	me 5 Heside 28d. Describe ho	nce 6 🗆 Oti w injury occur	rred	
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	Di To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the basis on the basis one and manners on the basis one and manners on the basis one one one of the basis one of the basis of	of examination and/or in	vestigation, in my op	inion, death occurre	ed at the time, da	use(s) and made, and place, odd. Date signe	and due to	the cause(s)
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ı	A		30. Name and address of person who completed cause of Ma # Law Mc No 3 \\ 31. Data filed (Month Day York) 4 \tag 23. Book	sy 494.	s Easte	m !	Ba1+1~	are, 1	up.	21224
1	Sta Registr		31. Date filed (Month, Day EP) 1 7 200 422. Regist	lative A	Aprock					

			1 - For Amend Item	17 State of M	aryland / Der	artmentofd ertificate of	Health a Death	and Mental	Hygier		29580
			1. Decedent's Name (First, Middle, L	.ast)	***				of Death		3. Time of Death
	Physici /Medio		Victor	Ε.	Olemab	e-Jacks	on	09		.2 200	
	Examin		4a. Facility Name (If not institution, g.	ive street and number		4b. City, Town,		of Death		4c. County of De	ath
			Northwest Hos	nital		Randa	listo	own		Baltim	ore
	Funeral		Social Security Number 6.	Sex 7. A	ge (In yrs. last birthday		If Under	24 Hrs. 8. Date	of Birth th, Day, Yea	9. B	irthplace (State or Foreign Country)
н	Director		615-94-5566	XXM 2□F	36 Yrs.	Monars Days	Hodio	01	05		igeria
	p 3		Usual Residence of Decedent  10a. State 10b. County	-	10c. City, Town or I	ocation					10d. Inside City Limits
	sho	5									1 □ Yes X\\\\X\\\No
	28a-1	ect	MD NA  10e. Street and Number		Baltim				10-	Oitimen of 14th - 4	1.0
	with a or	ä				10f. Zip Code			Tog.	Citizen of What (	Sounity?
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	ter d	Funeral Director	1 ☐ Never Married 2 ☑ Married	Armed Forces	?	If Yes, specify Cub	oan, Mexicar	n, Puerto Rican, et	c.)	Black, Wh	
336	ali, or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	-	1 ☐ Yes 2 💢 No	Specify:			Specify:	Black
21215-0036	72 hours after death with the Maryland natural; or itama 23a or 28a-f show dical Examiner must be motified at	Completed	15. Decedent's	Education	16a. Dec	edent's Usual Occu	pation		16b.	Kind of Busines	
215	within 7 ene. than "n	ble	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	(Giv (5+)	e kind of work done DO NOT use retire	auring mos ad)	t of working			
21	giene giene	Om	12th grade	6yrs		Machini	st			Compan	ys
pu	d 2 should be filed within 7 h and Mental Hygiene. 7 ie markad other than "traumatic event, the Med	Be (	17. Father's Name (First, Middle, La: Chief Adolphus				18. Mothe	er's Name (First, M	liddle, Maid	len Sumame)	
<u> a</u>	Ment Ment Ment Ment Ment Ment Ment Ment	2	Chief F. Adol	phus Ole	mabe -		Beat	rice O	duoch	ıa	
Maryland	and l		19a. Informant's Name/Relationship			ling Address (Street	t and Numbe	er or Rural Route I	Vumber, Cit	y or Town, State	, Zip Code)
	and salth n 27		Anthony Olemg	be-Broth		Glen A	rbor		altim	ore, M	d 21237
ore	iges 1 nt of H if iter or oth		20a. Method of Disposition	□Removal from State	20b. Place of Disp cemetery, cri	osition (Name of ematory or other pla	3C0)	Date	20c.	Location - City of	or Town, State
Ĕ	Pag ment ant: i		`4 □ Donation 5 □ Other (Spec		Family	Plot	]	10/8/04	Απ	aigbo,	Imo
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itame 23s or 28s-1 show any injury or other traumatic event, the Modical Examiner mant to notified at ODGs.		21. Signature of Funeral Service Lice	ensee		22. Name and Addr.	ess of Facility H Wes	st D	1		21215
-	_		23a Part1 Enter the disease or co	molications that cause	ed the death. Do not e	300 Wab	asn E	AVE, Ba.	LC1MC	re, Ma	21215 Approximate
			23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final	ly one cause on each					,,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Sev		onitis					24hrs
	Examiner			Due to (or a	s a consequence of):						4 lns
Я		e.	Sequentially list conditions,	b. Due to (or a	a consequence of):						24 1 10
	insit	ᇤ	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Nemal	ovanous	1277 VIVO 30.	altu				lux
,	execting and all-tra	Examiner	resulting in death) Last	C	s a consequence of):		-				
8760,	cate be executed physician and the burial-transit	dical		La Hu	pertension						2yrs
.89	ificat g phy as the	a l			7				, — — — — — — — — — — — — — — — — — — —		
Box	The law requires that the death certifit te has been signed by the attending to agge 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		C=				23d. Date of d	elivery
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		□Ectopic pregnanc □ Other (specify) _				Month	Day Year
P.O.	t the by the ache	hys	9 □ Unknown	9□ Unknown							
	res tha igned I be det	y P	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause gr	ven in Part I	. 23e.	Did tobacc	o use contribute	to the cause of death?
Ď	w require been sig should b		Hyper	horden	<u>U</u>				1 🗌 Yes	2 No 3 1	Probably 4 Unknown
Records,	s bee	Completed	V 4	,				24a.	Wasan	24b. Were	autopsy findings available
R	ding Physician: The lav h. After this certificate has funeral director, page 2	mo						10	autopsy performed? Yes 2 <b>X</b> I	? death?	
of Vital	an: rtifica for, p	Bec	25. Was case referred to medical	1			26. Place	of Death (Check		10 1016	2,25,10
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	tient 2 ER/Outpatie	ent 3 DOA Ott	her: 4 Nu	rsing Home 5	Residence	6 □Other (Sp	ecify)
0	g Ph ter th		27. Manner of Death	28a. Date of In (Month, D	jury 28b. Time Day Year) Injury	of 28c. Inju				jury occurred	
<u>io</u>	Attanding r death. sctor: After by the funer	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	ion			Yes 2	No			
Division	r Atts er de racto by th	tiflo	3 Suicide 6 Could not	ad 286. Place of Ir	njury - At home, farm, s	treet, factory, office		28f. Loca	tion (Street or Town, Sta	and Number or F	Rural Route Number,
Ö	rs after said on a said on	Certification:				e contract		0,		,	
	To the Hospital or Attandli within 24 hours after death, To the Funaral Diractor: A completely filled in by the fu	Medical (	29a. Certifier 1 Certifying I		it of my knowledge, dea of examination and/or i stated.						
	omple	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. [	Date signed (Mor	nth, Day, Year)
	/	2	> WILL	PL	Msizian	Do	0569	50	Se	ntembe	12,2004
1	10		30. Name and address of person wh	io completed cause of	death (Item 23a) (Type	, Print)					/
4	) '		Nnaemeka Aga	ijelu MD	8094 Ed	win Ray	nor Bl	VD Ste A	Pas	a dena	MD 21122
	Sta Regist		31. Date filed (MoStE Day, Year) 2	1004 32 legis	trar's Signature						(2, 20°4 MD 21122

				For State Registrar	State	of Maryla	-	artment rtificate			Mental Hy	giene	101.	20501
		Physici	an	1. Decedent's Name (First, Middle	,		_				2. Date of De Month	eath Day	Year	3. Time of Death
		/Medic	cal	Frederick Jo			•	4b City To	OMB OF	Location of Dea			3, 2004 punty of Death	5:15P. <sup>™</sup>
		Examir	er	Paradise Assis	-					ville	un	1	ltimore	
		Funeral			6. Sex		. last birthday)	If Under 1	Year	If Under 24 Hr			9. Birtho	lace (State or Foreign
		Director		217-09-0312	1 <b>∑</b> M 2□F	8	6 Yrs.	Months	Days	Hours Mir	June 5	, 1918	Mary	
		pur		Usual Residence of Decedent  10a. State 10b. County		10c C	ity, Town or Lo	ocation					1	0d. Inside City Limits
		Manyla I sho	ō			100.0								1 ☐ Yes 2 ₹ No
		the N	Director	Maryland Bal  10e. Street and Number	timore		Catons	10f. Zip C	Code			10a. Citize	n of What Coun	itry?
		3a ol		6348 Frederic	k Road				212	28		1	U.S.A.	•
		ems arm	Funeral	11. Marital Status	12. Was Dec	cedent Ever in l	U.S. 13.	Was Deceder	nt of His	spanic Origin? (	Specify Yes or North Rican, etc.)	0- 14	Race - Americ Black, White,	
	36	ours after death with the Marylan rel', or Items 23a or 28e-f show Expriliner must be retiffed at		1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, G	2⊠No live		1 ☐ Yes 2₹			nto mount oto.			
	Ö	hours	ed by	3 ☑ Widowed 4 ☐ Divorced  15. Decedent	Year or I	Dates:	16a Dogo	dosta Havel	0	*:			WI1.	ite
	15	in 72 n "ne de die	plete	(Specify only highes	t grade completed,		(Give	ident's Usual i kind of work DO NOT use	done d retired)	uring most of w	orking	160. Kind	of Business/Ind	dustry
न्त	21215-0036	d with giene ir the	Completed	Elementary/Secondary (0-12) 9	College	(1-4or 5+)	Sa1	esman				Beau	ty Supp	1y
14	pu	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28e-1 show eumatic event, the Medical Examinar must be redified at	Be	17. Father's Name (First, Middle, I	Last)					18. Mother's Na	ımə (First, Middle	, Maiden St	umame)	
μ_	<u>ya</u>	Ment Ment arkec	10	Frederick J		iger, Si	r.			Elizab	eth Baum	eiste:	r	
~	Maryland	2 sho		19a. Informant's Name/Relationsh		TT (C)					Rural Route Numb	-		
يق		ges 1 and 2 should t of Health and Men If item 27 Is marke or other treumatic		Frederick J. Pre	earger, 11		Place of Dispo	osition (Name	of -		Baltimor Date		ry Land A	
Prediger	Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 eny injury or other tr once.		1 ☐ Burial 2 🖾 Cremation		State	cemetery, cre	matory or oth	er place					
ર્ચ	Ħ	artme orten injury		*4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service I		ва	Ito./Wa	asn.Ure 2. Name and	emat Addres	ory 9-4	20-2004	Laure	1, Mary	Land
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			Г	23a. P. tt1. Enter the disease, or sho k or hear failure. List	complications that	caused the dea						-	ic, iib	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition		109129	SIVE	Den	nen	Ha.				Onset and Death
		/Medical Examiner		resulting in death)	Due to	o (or as a conse		<b>V</b> -0,	.,	1100				
		Examiner	بـ	Sequentially list conditions,	b	(								
		ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated ouests)	Due to	o (or as a conse	equence or):							
	_,	execut n and al-trar	xar	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):							
	8760,	ate be executed thysician and the burial-transit	dlcal		d									
	9	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medi	IF FEMALE:	1									
	Box	eath certific attending pi	Physician/Me	23b. Was decedent pregnant in the past 12 months?		utcome of pregr birth 2 Tee		⊒Ectopic preg	gnancy			230	d. Date of delive Month	ry Day Year
	O.	the all	/sici	1  Yes 2 No	4□Preg 9□Unki	gnant at time of nown	death 5	Other (spec	cify)				MOULL	Day 18ai
	P.O.	that the de ed by the detached		Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	underlving cau	use aive	n in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
	ds,	uires tha signed Id be del	d by					, , ,				Yes 2		• •
	COL	w requir been si should	lete								24a. Was	an :	24b Were autor	osy findings available
	Re	The la te has age 2	Completed								auto	psy ormed?	prior to con death?	npletion of cause of
	of Vital Records,	sicien: The law certificate has b irector, page 2 s	O	25. Was case referred to medical						26. Place of De	1 ☐ Yes eath (Check only	2 No one)	1 🗆 Yes	2L No
	>	Physicien: r this certificated in the control of th	To B	examiner? 1 ☐ Yes 2 X No			☐ ER/Outpatie	nt 3 DOA	Othe	4 Nursing	Home 5□Res	idence 6 D	Other (Specify	Assisted Living
1	O L	ding Pl h. After ti funera	on:	27. Manner of Death  1 XNatural 5 ☐ Pendin	g 28a. Date	e of Injury onth, Day Year)	28b. Time o		c. Injury Work	at ?	28d. Describe			
A	Division	Attendi death. ctor: A y the fu	Certification:	2 Accident investig 3 Suicide 6 Could r	not be	a of labor. At l	h (	M		'es 2 □No	ORE Laureign	(Character and )		
	Div	I or All	ertlf	4 ☐ Homicide determ	ined 286. Place	ce of Injury - At I ding, etc. (Spec	nome, rarm, st zify)	reet, factory, (	office			wn, State)	vumber or Hura	l Route Number,
	_	spitel tours nerel		29a. Certifier 1 Certifyin	g Physician: To th	ne best of my kr	nowledge, deal	th occurred at	t the tim	e, date and plac	e, and due to the	cause(s) ar	nd manner as st	ated.
		To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examir nner stated.	nation and/or in	nvestigation, in	n my op	inion, death occ	curred at the time.	date and pl	lace, and due to	the cause(s)
_		To the To the Comp	×	29b. Signature and title of certifier	•			- 1		number			signed (Month, I	
		$\sim$		* AVIIIMEN	10 mo			D	00	5 6 12	.21	Septe	mber 1	15,2004
		10		30. Name and address of person	who completed cau	use of death (Ite	em 23a) (Type	, Print)	,	المما	.4.4	1 /	1	15,2004
				Ledy S D. Mars 31. Date filed (Month, Day, Year)		25 Ma Registrar's Sign	in Str	veet k	(18)	restou	n mar	y land	•	
		St Regist	ate rar	SFP 1		Journal of Sign	K .	land.				•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 4:07 AM KEGINALI LRNEST 200-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARUNDE ANNE ARUNDEL GENERAL Birthplace (State or Foreign Country)
 ANADA Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** 30x 10 M 2□ F Months Days Hours Min. 219-42-2326 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or than "natural", or items 23e or 28a-f show the Medical Exposit er out the notified at 1 ☐ Yes 2 ☐ No Director ARUNDE ANNE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 481 IEN JITED Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2☑ No Specify: WHITE Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tree 20c. Location - City or Town, State DE 1481 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State ANATOMY OIFTS KEG. 4 
 ☐ Other (Specify) ral Se lice Lice 21. Signatu 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Du (or as a consequence of): Friysician disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 4☐Pregnant at time of death Day 5 Other (specify) 1 ☐ Yes 2 ☐ No o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 140 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 has autopsy performed? certificate 2 Yes of Vital or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 4 Nursing Home 5 Residence 6 Dother (Specify) 1081 TAL 20 2 1 No 1 🗌 Inpatient 2 TVOutpatient 3 DOA this To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Registrar SEP 1 7 2004

Hours Lowe

31. Date filed (Month, Day, Year)

INBURTE

Colony Dr., Annorsis, M.

completed cause of death 1 m 23a) (Type, Print)

32. Registrar's Signature

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			For State Registrar	State of Marylan		tificate of			g. No. 1) 1	20502
			Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
	Physicia		ANDREAS	M. RICH	IARI	SON	SR.	September	r 16, ZOOY	1:45 AM
H	/Medic Examin		4a. Facility Name (If not institution, give :	_ ,			or Location of Death	1	4c. County of Deat	h
			Since Hospital	of Beltineon		Baltimo			N/A	
	Funeral Director		5. Social Security Number 6. Sec 218-58-7645	7. Age (In yrs.  M 2□ F 48	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
			Usual Residence of Decedent	10				INCHEMISER	16,1955 MAI	ZYLHND
	nylan show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo					10d. Inside City Limits
	Ba-1	ecto	MARYLAND NIA		>HZ71	MORE			(11)	1 TYPYes 2 □ No
	with t	Funeral Director	1821 ROXTO	N AVENL	E	10f. Zip Code 2/2	110	10	Og. Citizen of What Co	untry?
	ns 23	era		12. Was Decedent Ever in U			Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,
9	after or ita	Fur	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give		f Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	
5-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		•			Specify: 12	LACK
<u>-</u>	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show its Mudical Examina initial be indiffied at	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of worl	king	16b. Kind of Business/	Industry
212	y withi	omb	Elementary/Secondary (0-12)	College (1-4or 5+)	AUT		CHANI	2 3	SELF EM	PLOYED
g	be filed Ital Hygid of other event, I	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M	Maiden Surname)	
<u>  a</u>	should b nd Ment marked umatic e	Tol	ROBERT	RICHAR			DORIK		SHERR	
Maryland 2121	200		19a. Informant's Name/Relationship (Ty BONNIE BURNS						City or Town, State, 2	
	s 1 and if Health itam 27 othar tr		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of			ORE MD &	
OE .	t. Pages rtment of I rtant: If it		1 Burial 2 □ Cremation 3 □ F  1 □ Donation 5 □ Other (Specify)	semoval from State		natory or other place. NORIAL PA	' I	21-2001 P	AITIMORE	MARYLAND
Baltimore,	permit. Pages Department of Important: If i any injury or one		21. Signature of Funeral Service Licens							
<u> </u>	88 2 2 8		Wietrich	N. William	ns 3	SEM M 40 N.F.	ULTON A	IE, BALT	INERAL ,	21217
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deat ne cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition resulting in death)	a	Artery	Disca	a			14 mouts.
L	/Medical Examiner			Due to (or as a conseq HIV	juence of):					17 years
b,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):					
	cuted nd ransit	Examiner	that initiated events	c						
760,	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a conseq	juence of):					
6876		dicai		d						
× 6	that the death certifica ed by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy				23d. Date of dei	iverv
P.O. Box	death e atter d for u	lciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnancy Other (specify)	y		Month	Day Year
0	by the	hys	9 Unknown	9□ Unknown					787	
ŝ	ngi be	by F	Part II. Other significant conditions con	To it is the second of the sec	oulting in the u	nderlying cause giv	4.4		acco use contribute to	
Vital Records,	v requir been si should	Completed by	ETRI STEPL RELLE	Failure, Hep.	(50/110)	0, 10	4117 105	-		obably 4 Unknown
Sec	ne faw has b	mpl	0 // /		is my	o pethy.		24a. Was ar autopsy perform	prior to o	topsy findings available completion of cause of
a	n: Th	e Co	25. Was case referred to medical	necteurist			OC Place of Page	1 ☐ Yes 2	No 1 □ Yes	2 No
	Physician: this certificatal director, p	o B	examiner?	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ott	200		nce 6 Other (Spe	city)
O L		on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injur	ry at	28d. Describe ho		
Sio	Attanding or death. actor: After by the fune	cath	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □No			
Division of	= 00 >	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti ly)	eet, factory, office		28t. Location (Str City or Town	reet and Number or Ru , State)	ral Houte Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, deat	occurred at the tir	me, date and place,	and due to the ca	use(s) and manner as	stated.
	ha Ho n 24 t ha Fu pletely	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	ppinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	/ ^/A		29c. Licens			d. Date signed (Monti	*
	, χ		1. Bradaus			KES-	-000	Se	ptember	16, 2004
	10		30. Name and address of person who co	ompleted cause of death (Iter USKAITE)		Sinoi	Hosi. to	1 of	eptember Beltimer	_
	Sta	ite	31. Date filed ( A th Day Year)	Registrar's Sign	ture	-17 Lucy		· //		
	Registi		Bran. 4 . COO4	Justine 1	6	all a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2050 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John Wade Robinson, Jr. September 2004 9:35 a 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2933 N. Calvert Street, 1st fl frt N/A Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 31, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Year) 1953 1**⊘**M 2□F Days Hours Min 51 Yrs. Director 213-60-3412 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show ury or other treumatic event, the Medical Estiminar must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 BYes 2 No Director MD N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2933 N. Calvert Street, 1st fl frt. 21218 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 71 = 71 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) Roofer 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Wade Robinson, Sr. Thomasena Plowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Thomasena Robinson/Mother 3838 Roland Avenue, Apt. 1106, Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sep 15 permit. Page Department o Important: If any injury or Beltsville, MD 1 4 Donation Chesapeake Crematory 2004 21. Signature of Funeral Service 22. Name and Address of Facility
Cremation and Funeral Alternatives MO0984 8717 Green Pastures Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Physician W Dan disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events s a consequence of): Completed by Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transil resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1° Natural 2 Accident 5 Pending investigation s after decreed Director: After M 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) SEP 17 2004

BRUK

ONKOFF Registrar's Sign

K.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Records,

Division of Vital

JE80

· Greens

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Day Year KOSE SRMAN 10:00AM 09 04 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner**  Birthplace (State or Foreign
 Country) **Funeral** Days 1 M 2 □ F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Midical Examiner must be notified at 1 **≥** es 2 □ No Completed by Funeral Director more 10f. Zin Code 10g. Citizen of What Country? items 23a Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specity. Specify 3 ☐ Widowed 4 ☑ Divorced "natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working The. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. ondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle is marked of Pages 1 and 2 should be Davy Her 19b. Mailing Address (Street and Number or Rural If item 27 i Da. Method of Disposition 1 2 Purial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee /aux 23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to firm edials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Certification: To Be Completed by Physician/Medical Examiner for as a consecuence of or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an page 2 s 1 Yes 2 No Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred injury at Work? Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after deat 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
SEP 1 7 2004

DHMH 17 Rev 1/2001

State Registrar

Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Year W. Raab 12:25 AM P 0 George 13 2004 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 5. Social Security Number BALLMORS If Under 24 Hrs. 8 Ylursinb Home 7. Age (In yrs. lest birthdey) If Under 1 Year Months Days 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 7 M 2□ F Yrs. 214-20-3320 Oze 20 1922 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours elter death with the Marylend Department of Health and Mentel Hyglene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show any fujury or other traumatic event, the Modical Exercites must be notified at once. 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No **Funeral Director** MARLAND BALLIMORE ARKYILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ROAD U.S.H. 3318 FOI WILL GILL 21334 Vairs 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No If Yes, Give Year or Detes: ₩ ₩ ₩ 1 ☐ Never Married 25 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 25 No Specify: ٥ Specify: 3 Widowed 4 Divorced THW Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PERINTENDENT 9YRS. LONSTRUCT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GIORGE 19. KOPPLIMAN LIDA 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) SCIENRORO UNIT B. HARKINE MO KITAA 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 7-13 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State ROSEDAL 4 ☐ Donation 5 ☐ Other (Specify) HTIAT 70 CAZUSAD 22. Name end Address of Facility Manager 25 21. Signature of Funeral Service Licensee 31934 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 3800 HARFORD 1600 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Candio Pulman Examiner Medical Certification: To Be Completed by Physician/Medical Examiner 2 CVI The law raquiras that the death certificate be executed Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contribute to the cause of death? 12⊈ Yee 2 □ No 3 Probably 4 Unknown A.fib, CRI, 24b. Were autopsy findings available prior to 24a. Wes en eutopsy ckwickian Syndrome completion of cause of death? 21 No 1 Tes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🚜 No 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 27. Menner of Deeth 28d. Describe how injury occurred Naturel 5 Pending Injury investigation 1 Yes 2 No 2 Accident Dirsctor: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner steted. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 60539 - 2006 30. Neme end eddress of person who comple ed cause of deeth (Item 23e) (Type, Print) R. Heade 821 N Eulous St., Suite 308, Baltman, MD 21201

Registrar **DHMH 16 Rev 6/95** 

State

104 31. Date filed Month, Day, Year

SEP 1 7 2004

Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Yeer **Physician** SULLIVAN MARY 09 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3 BALTIMORE NA CARE FALL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)

AUGUST 4, 1924 MARY LAND 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2 F 215 24 6058 78 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at BALTIMORE 1 Yes 2 No Funeral Director MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death ! 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 W No f Yes, Give Year or Dates: ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK ģ 3 Widowed 4 □ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, IDE MORE. PRIVATE HOMES 11TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS HENRY JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERNADETTE IRATHEK ST, BALTIMORE, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 

Burial 2 □ Cremation 3 □ Removal from State ZION CEMETERY 09-22-2004 LANSDOWNE, MARYLAND \* 4 ☐ Donaylon 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility
SOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1000 /Medical Due to (or as a consequence of): Examiner Clockson vars Sequentially list conditions, if any, leading to initialist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tue to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed Inna Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 1 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Entow It Soute 30d, Balt MD 2120 J'HOAIB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 7 2004 Registrar

			For State	State of Marylan		artment of H		,	0001	0.05.00
			Registrar  1. Decedent's Name (First, Middle, L	ast)	Cel	incate of	Dealli	2. Date of Dea	leg. No.	3. Time of Death
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	/Medio Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Death	19	4c. County of Dea	
			Harbur Huspital:	3001 South Hanwer	Strant		timore		N	A
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. 1 M 2 F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	, Year C	thplace (State or Foreign
	Director		Usual Residence of Decedent	/(	) 113.			FEB 2	7,1737 17.	ARYLAND
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	a-f st	to	MARYLAND	JA		BALT	MORE	CITY		1 ⊠Yes 2 □ No
	or 28	Director	10e. Street and Number	10		10f. Zip Code	1HORE		10g. Citizen of What C	•
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	ter de	by Funerai	<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🗷 No	.5.	f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
93	al', or	þ	3	If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Specify:	LACK
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ary	should ind Men s marke umatic	-	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	and Number or Ru	rai Route Numbe	r, City or Town, State,	Zip Code)
- 10	1 and 2 Health a tem 27 is		JOANN SMIT	TH (DAUGHTER)	343	245PEL	LMANR	D. BA	LTO. MD	2/225 Town, State
Baltimore	e = = =		20a. Method of Disposition 1 □ Burial 2 XCremation 3		Joinialary, Ciar	natory or ourer place	Je)			
tim	tment tant:		* 4 □ Donation 5 □ Other (Spec	city) ME	ETRO	CREMATO	TRY 09-	20-04	BALTIMO	RE, MAKYLAND
Bal	permit. Pag Depertment Important: any injury conce.		21. Signature of Euneral Service Lic	ensee	22	Name and Addre	ss of Facility 3	ROWN	OK, FUN	RE, MARYAND ERAL HOME 10.21217
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- 6	Physician	9	shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.	1 (	BIPas	1 -			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a consec	uence of):	piras	t Canc	0)		
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Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of de	
_	the at	/sici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time of c 9□Unknown	ieath 5	Other (specify)			Month	Day Year
P.O.	res that the de signed by the a be detached f	by Physician/Me	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contribute to	the cause of deaths?
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> >	Physician: this certific al director.	10 E	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing H	ome 5 Resid	ence 6 Other (Spe	ocify)
n o	fter	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe h	ow injury occurred	
Division of Vital	Attending r death.	icat	2 Accident investigat 3 Suicide 6 Could not	be 200 Bloom of Injury At h	ome farm str		Yes 2 □ No	28f Location (S	treet and Number or R	ural Route Number
Ď	after Direct	Certification:	4 ☐ Homicide determine	building, etc. (Special	fy)	eet, factory, office		City or Tow	n, State)	urar noute Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying	Physicien: To the best of my know	owledge, deat	n occurred at the tir	me, date and place,	and due to the o	ause(s) and manner a	s stated.
	the Ho in 24 the Fu	Medical	one)	aminer: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	ppinion, death occu	rred at the time, o	late and place, and due	o to the cause(s)
	With To T	Σ	29b. Signature and title of certifier	11/1	0)	29c. Licens			29d. Date signed (Mont	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrer	State of Marylan		tificate of I		vientai Hygier Reg. i	2001.	29589
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  JRMs S	nere				2. Date of Death Month	Day Year	/. > AM
	Examin Funeral		4a. Facility Name (If not institution, give s  Northwest Hos  5. Social Security Number 6. Sep.	pital Cente		4b. City, Town, or Randal  If Under 1 Year  Months Days	Location of Death  1stown  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, Ye. Sep. 20, 1	Baltim 9. Bi	ath/ Ore rthplace (State or Foreign ountry)
poet	Director		212-52-7749  Usual Residence of Decedent  10a. State  10b. County	55	y, Town or Lo	cation		Sep.20,1	948   Ma	ryland  10d. Inside City Limits
di di	or 28a-f sl	Director	MD Baltimo		vings	Mills 10f. Zip Code		10g. (	Citizen of What C	1 ☐ Yes 🏋 💢 No
1 Z 1 3-0036	or faint 2 shoots be mer within 2 hours shert death with the way fair front and Mantal Hygiene. I Health and Mantal Hygiene. I health and Sa or 28a-f show titm 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, if a Moulical Experiment must be notified.	by Funeral Director	3 Saddlesstone  11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Amed Forces?  1 Yes Tho If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sin, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	U . S  14. Race - Am Black, Whi	encan Indian, ite, etc.
9500-61212	al Hygiene i other then "netural vant, the Medical El	Completed k	(Specify only highest grade	cation	(Give life. L	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of wor. )	king 16b.	Kind of Business	White Madustry c Televisi
ם פֿ	and Mental Hygins and Mental Hygins Is marked othar aumatic evant, I	To Be Co	17. Father's Name (First, Middle, Last)  James Severe		Auu	Eligin	18. Mother's Nam	ne (First, Middle, Maid	en Sumame)	
a a	othar traume		19a. Informant's Name/Relationship (Ty.  Suzanne Severe  20a. Method of Disposition	/ Spouse	3 Sa		one Co			1s,MD 2111
Baltimore,	Department of Himportant: If its any injury or ot once.		X Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)  21. Signature of A peral Service License	emoval from State A1	1 Sai	nts Cem . Name and Addres	Sep.	khardt F	uneral	Chapel P.
	hysician and businistransit as the privile-transit	edicai Examiner	23a. Part 1. Enteyfhe disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Extra traditions (Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).  Due to (or as a consequence).	uence of):		Somy of			Approximate Interval Between Onset and Death
ords, P.O. Box		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ras, r	been signed t	by	Part II. Other significant conditions cor	stributing to death but not resi	ulting in the ur	nderlying cause give	on in Part I.	23e. Did tobacci		o the cause of death?
I Kec	ate has b	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 Ø	prior to	utopsy findings available completion of cause of 2 No
Division of Vital	leath. tor: After this the funeral direction	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hobiding, etc. (Specify	ER/Outpatien 28b. Time of Injury ome, farm, stre	28c. Injury Work M 1 🗆 \	at Nursing H	th (Check only one) ome 5 Residence 28d. Describe how in 28f. Location (Street. City or Town, Sta	jury occurred and Number or R	
2	24 hours Funaral	edicai Ce	29a. Certifier 1 Certifying Physical Certifying Physical Exemination (Check only one)	sicien: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place, inion, death occur	and due to the cause red at the time, date a	(s) and manner as	s stated. to the cause(s)
1	within 2 To tha complet	Mec	29b. Signature and title of certifier	Hist		29c. License	0 -		Pate signed (Mont	
12	Sta	ite	30. Name and address of person who co	mpleted cause of death (Item 32 degistrar's Signa	t 1	esp ter	1 Ran	depotou	n he	16,7004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item#26, State pint and Am 1. Decedent's Name (First, Middle, Last) 2. Date of Death Stadler Day **Physician** Month Year 5.55PM 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Center timore If Under 24 Hrs. 7. Age (In yrs. last birthday)
Yrs. 5. Social Security Number () 6. Sex 9. Birthplace (State or Foreign **Funeral** 1□M 20 F Months Days Hours Min. 1292 Director Usual Residence of Decedent 10a, State #10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner roust by notified at Be Completed by Funeral Director 1 ☐ Yes 2 No recc Ha 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a or 1236 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced Whit 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Internal Audit pecialis7 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Maril ပ္ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elderberry 25 atonsville If Item 27 Colacio 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 P
4 Donation 5 Other (Specify) 3 Removal from State permit. Page Department of Important: If any Injury or once. EVANS FUNERAL CHAPEL 21. Signature of Funeral Service License 22. Name and Add tives tuneralt e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line Approximate Interval Between Immediate Cause (Final ances **Physician** disease or condition resulting in death) 1480216 m/t /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or it]ury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 🗌 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? (es 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 1 🗌 Yes 2 / No 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home esidence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗆 No within 24 hours after death

To the Funeral Director: /
completely filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 28b. Signature and title of certifier 29d. Date, signed (Month, Day, Year) 29c. License number D18487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

ANDPIPER

rar's Signature

8114

THANT 31. Date filed (Month, S.E. Par) 7 2004 32. Re CIRCLE, BACTO MD 2123

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item#9 11 per PH 6835 9/17/04 TT State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	F	Reg. No.	21 0	00001
	Physici	an	1. Decedent's Name (First, Middle, Last)  OANINY  TESTERMON	2. Date of Dea	th Day	Xea /	3. Time of Death 1:20 P.M.
7	/Medio		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Loc	cation of Death	4c. County	of Death	1:20 1.11.
	LAGIIII	iei	MILLENEUM FRANKLIN SOBALTIM	ORF.	BAL	TC	ITV
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Yeak 1 If Under 24 Hrs. Months Days Hours Min.  Usual Residence of Decedent	8. Date of Birth (Month, Day Januar)	Year 1947 y 16,	9. Birthplace Countil	e (State or Foreign
	yland now		10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Limits
	e Mar	Director	MD BALTIMORE MC	)			1 Yes 2 No
	ath with th		10e. Street and Number 28/3 GANLEY DR. 21230		10g. Citizen of the	What Country	+
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Itama 23a or 28a-f show may finlury or other treumatic evant, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 Never Married  1 Never Married  2 Married  1 Never Married  2 No specify:  1 Yes 2 No Specify:  1 Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Rad Blad	ce - Američan ck, White, etc.	
21215-0020	rithin 72 h Je. Jan "netu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	ng	16b. Kind of B		
	Hygier Hygier thar th		7 0 Factory Worker  17. Father's Name (First, Middle, Last) 18. Mother's Name	/First Middle	Keysto:		ctric
Maryland	d 2 should be filed within th and Mental Hygiene. 7 Is marked othar than "treumatic evant, the Men	To Be	Allen Testerman Alice	_	ae	,	
lary	2 shou and N is mar eumat	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	l Route Numbe	r, City or Town,		,
	1 and 2 Health em 27 I		Laura Testerman (Ex-Wife) 2813 Ganley Drive, Balti				
Baltimore,	permit. Pages Department of h Importent: If ite any injury or of ance.		1 □ Burial 2 🗷 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Bayview Crematory 09	Date 9-15-04	Baltim		
Bal	permit. Departr imports any inji		21. Signature of Fungral Service Licensee  22. Name and Address of Facility McCully-Polyniak Fun 237 E. Patapsco Aven	nue Bai	ltimore		21225 and
			23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory ar	rest,	Ap Int	pproximate erval Between nset and Death
Ž	Physician /Medical		Immediate Cause (Final disease or condition ACQUIRED (MMUNE DEFIC	TEIR	SVA		JEA )
	Examiner		disease or condition resulting in death)  Due to (or as a consequence of):	Licray	3410	Curt	TOILS
	ait sit	iner	<b>a</b> h			1	
, 0,	requires that the death certificate be executed een signed by the attending physician and hould be deteched for use as the buriel-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury c.			-	
68760,	ificete b g physic as the b	Medical	that initiated events resulting in death) Last  Due to (or as a consequence of):				
Вох	that the death cer ed by the attendin deteched for use	an/N	d			<u> </u>	
	ne dea the at thed fo	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco use co	ntribute to the	e cause of death?
, P.O	that the	by Ph		ų⊡γ́	ea 2□No	3 Probabi	ly 4 ☐ Unknown
Records,	aw Is b	Completed b		24a. Was a perfor	an autopsy med?	availat	autopsy findings ble prior to etion of cause th?
	T ate	Con		1□ Y	es 2□No	1 □ Y€	es 2 No
of Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital: Other: Other:				
J of	두 두 절	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28		ence 6 □Oth ow injury occur		
sior	Attanding ir death. actor: After by the fune	atio	2 Accident investigation M 1 ☐ Yes 2 ☐ No				
Division	or Att after d Diract Jin by I	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (S City or Town	treet and Numb n, State)	er or Rural Ro	oute Number,
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune.	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	nd due to the c od at the time, d	ause(s) and ma late and place,	inner as stated and due to the	d. e cause(s)
	within To the	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signe	d (Month, Day	, Year)
			Metteans M. 1) DOUSTOS 57	F   S	triems	ER 1	4 2004
_	H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WHOH CASH SZ ( N. EVTAN STREET	7,88	htim or	17 1	prizal
	Sta Registr		31. Date filed (Month, Day, Year) 7 2004 32. Registrar's Signature				

			1 - For Stata Registrar	State of M	arylan	-	artmen rtificat			and M		Reg. No.	104	29592
	Physici /Medic		1. Decedent's Name (First, Middle, Las Helen			Thomas			-		2. Date of Dea Month Septem	ber 2,	Year 2004	3. Time of Death
). 	Examin	er	4a Facility Name (If not institution, give Mariner Health o	f Forest	Hill	( a   a	4b. City,	Fore	Location of the Location of th	i11_	o Day of Bird		Harfor	
	. Funeral Director		5. Social Security Number 6. S 217–40–5379 1  Usual Residence of Decedent	a	91	/ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 1946, 2)	y, Year)	9. Birth	place (State or Foreign ntry) FNNSULVANIV.
	Maryland -1 show	tor	10a. State 10b. County N/A			y, Town or Lo Baltin								10d. Inside City Limits  O∰Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 1115 South Bonsa	l Street	- <del>-</del>		10f. Zip	Code 212	224			-	of What Cou	ntry?
036	s 1 and 2 should be tiled within 72 hours after death with the Maryland if Health and Mantal Hygiene. Itam 27 Is marked other than "natural", or Itams 23s or 28s-1 show other traumatic event, the Medical Examiner must be invited at	by	11. Marital Status  1 Never Married 2 Married  3 Vidowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	Ever in U. No		Was Decedif Yes, special		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, ecify: Wh	
21215-0036	e tiled within 72 ho al Hygiene. I other then "netur vent, the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	(Give lite.	dent's Usua kind of wo DO NOT u omemal	rk done d se retired	turing most	t of work	ing		of Business/Ir n Home	ndustry
Maryland	2 should be tiled and Mental Hygi Is marked other aumatic event,	To Be (	17. Father's Name (First, Middle, Last) Adam Platt						Flor	cence	e (First, Middle, e Stahl			
	is 1 and 2 sh of Health and itam 27 is m other traum		19a. Informant's Name/Relationship (  Janet Putnam  20a. Method of Disposition	Type, Print)	20h P		Furr	ace		Fal:	1 Route Number $1$ Ston, $1$ Date	Maryla		)47
Baltimore,	t. Page rtment o rtant: If njury or		Burial 2 □ Cremation 3 □     4 □ Donation 5 □ Other (Specification of the control of the c	/)	,   0	emetery, cre. k Lawr	ceme	etery	7	9/7	/04	Balti	more,	Maryland on, Inc.
■ Ba	permi Depa Impo any ir		23a. Pard Phter the disease, or com		d the deat	6	224 E	Easte	rn Ay	zenue	e Baltiı	more,		and 21224 Approximate
*	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ine. Prei	7_	pn	·	in					Interval Between Onset and Death
8760,	s be executed sician and purial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underfying Cause (Disease or injury that initiated events resulting in death) Last	b										
O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	I death 3[	⊒Ectopic pi ⊒ Other (sp					23d.	Date of deliv	ery Day Year
rds, P.	sign d be	ρ	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	inderlying o	ause give	en in Part I.					the cause of death?
of Vital Record	The law ate has b page 2 sl	Completed											prior to co death?	opsy findings available ompletion of cause of
Zit:	Physician: this certifica al director, p	Be	25. Was case referred to medical examiner?	Hospital:		ED/0 /		. Oth			(Check only o			
	ing After unel	ition: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inj (Month, Da	urv	28b. Time of Injury		28c. Injury Work	/ at		me 5 Resid 28d. Describe h			fy)
Division	in Sir de	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	ijury - At ho tc. (Specif	ome, farm, st	reet, factor	y, office			28f. Location (5 City or Tov		umber or Run	al Route Number,
	To the Hospital or within 24 hours attended to the Funeral Directory completely filled in the co	edical	29a. Certifier (Check only one)  Certifying Principle (Check only one)	ysician: To the besi niner: On the basis and manner s	of examina	wledge, deal tion and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and date and pla	d manner as s ce, and due t	stated. o the cause(s)
\	To t To t	Σ	29b. Signature and title of certifier						number				gned (Month,	
7	19		30. Name and address of person who			n 23a) (Type	Print)	,			2100		r ),	2004
Ì	St Regist		31. Date filed (Month, Day, Year) SEP 1 7 20	32 Regist	rar's Signa	× 4	od)					-		

Melanie Worley

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	
State of Mar	yland / Department	of Health and M	ental Hygiene

04-05934	:		State of Maryland / Depart	artment of Health and I	Mental Hya	iono	
MAN		1 - For Stata Registrar		rtificate of Death		0001	20500
		Decedent's Name (First, Middle, Last		timodio of Boath	2 Date of Deat	eg. No.	3. Time of Death
Physic		Melanie Ann			Septemb	er 14, 2004	4 0828 A M
/Medi Exami		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Deat	
LAUIII		Bayview Medical Co	enter	Baltimore		N/A	
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,		hplace (State or Foreig
Director		214-04-1230	□ M 2 <del>X</del> F 22 Yrs.	Months Days Hours Min.	April 1	14,1982 Mar	vland
p v		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo				
laryla sho	2		Too. Only, Town of Ec				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
he M	Director	Maryland N/A  10e. Street and Number		Baltimore			21
with a or 3	D.	3600 Hudson Stre	et	10f. Zip Code 21224	1	0g. Citizen of What Co	untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avant. The Medical Examination and injurial at any pince.	Funerai	11. Marital Status				U.S.A.	
iten d	F.	1 Never Married 2 Married	Armed Forces?	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
urs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Whi	te
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 77 is marked other than "natural", or traumatic avent, the Medical Exam	Completed	15. Decedent's Ed	ucation 16a. Dece	dent's Usual Occupation		16b. Kind of Business/I	
212 Pin 7	pje	(Specify only highest gra	College (1-4or 5+)	kind of work done during most of worl DO NOT use retired)	king	Johns Hopk	ins Univer
21 maignage and an	Con	12		omer Service		Press	
nd se file d oth	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Nam	e (First, Middle, A		
Van	2	Phillip Worley		Kat	hleen Wa	tson	
and and is m		19a. Informant's Name/Relationship (7		ng Address (Street and Number or Rus	ral Route Number,	City or Town, State, Z.	ip Code)
and and m 27		Kathleen Worley-M		) Hudson Street Ba	altimore.	Maryland	21224
Ord Of H		20a. Method of Disposition 1	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place)	Date	20c. Location - City or 1	Town, State
altimore, mit. Pages 1 ar partment of Hea portant: if item y injury or othe		'4 Donation 5 □ Other (Specify	9 Oak Lawn	Cemetery 9/18	3/2004	Baltimore,	Maryland
Sall ermit epart nport ny in		21. Signature of Funeral Service Licen	see 22	<ol> <li>Name and Address of Facility Cha</li> </ol>	rles S.	Zeiler & S	on
<b>n</b> && <b>E &amp; 8</b>		Jessue !	000	224 Eastern Avenu	e Baltim	ore, Maryla	and 21224
		23a. Part1/Enter the disease, or comp shock or heart failure. List only	plications hat caused the death. Do not ent one cause on each line.	er the mode of dying, such as cardiac	or respiratory arre	est.	Approximate Interval Between
Priysician		Immediate Cause (Final disease or condition	a. Pulmonary Th	romboembolism			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
LAGITITIE	L	Sequentially list conditions,	b				
sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause fine flux artying Cause (Disease or injury	Due to (or as a consequence of):				
68760, ficate be executed physician and ts the burial-transit	xarr	that initiated events resulting in death) Last	c Due to (or as a consequence of):				
8760, cate be exphysician	E		bue to (or as a consequence or).				
Cate physithe	dicai		d				
Hecords, P.O. Box 68760,  The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				
Bo Bath d atten for u	Physician/M	in the past 12 months?	1 Live birth 2 Fetal death 3 ☐	Ectopic pregnancy		23d. Date of deliv Month	rery Day Year
at the de by the a	ysic	1  Yes 2  No 9  Unknown	9 Unknown	Other (specify)			
IS, P.	/Ph	Part II. Other significant conditions co	entributing to death but not resulting in the un	ndertying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
dS uires sign d be	d by			, ,	1 □ Ye	s 2□No 3□Pro	babiy 4 🕅 Unknown
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has be 2	mp				24a. Was an autopsy perform	prior to co	opsy findings available empletion of cause of
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Vital sician: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:	Other	h (Check only one		
Phys rthis ral di	- T	1X Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatien  28a. Date of Injury 28b. Time of	4 Hursing Ho	me 5 Resider	nce 6 Other (Speci	fy)
ding h. After funer	tion	1 X Natural 5 ☐ Pending	(Month, Day Year) Injury	28c. Injury at Work?  M 1 Yes 2 No	200. Describe not	w injury occurred	
VISIO VITANDI Geath. ctor: A y the fu	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, stre		28f. Location (Str	eet and Number or Run	al Poute Number
DIVISION OF  if or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	4 Homicide determined	building, etc. (Specify)		City or Town,	State)	
pite ours fille		29a. Certifier 1 Certifying Phy	vsician: To the best of my knowledge, death	occurred at the time, date and place.	and due to the car	use(s) and manner as s	stated.
te Hos 124 h	Medical	(Check only one) Medical Exam	iner: On the basis of examination and/or inv and manner stated.	restigation, in my opinion, death occur	red at the time, da	te and place, and due t	o the cause(s)
To the I within 2 To the I	Me	29b. Signature and title of certifier		29c. License number	29	d. Date signed (Month.	Day, Year)
*		I him his	mid	O.C.M.E.	S	eptember 15	5, 2004

State Registrar

31. Date filed (Month, Day, Year)

LING LI MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Carlton Adrian Ahern 30 5:55 AM 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Hospital Cumberland Hearl pacred If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X** M 2□ F Months 72 234-48-3123 West Virginia Director 12/29/1931 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event, Ita M. Jical Ex., illier is ust be natified at once. 1 ☐ Yes 2 No Director Mineral Ridgeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Roy Drive (Route 4 Box 181) 26753 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1∆ Yes 2 □ No 1950 - If Yes, Give Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Laborer Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Robert Ahern Mae Butts <sup>o</sup>L 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy J. Ahern / wife Route 4 Box 181, Ridgeley, WV 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Davis Memorial Cem. 109/02/2004 ` 4 □ Donation Cumberland, MD 6 ☐ Other (Specify) 21. Signature of Feneral Service Licensee. 22. Name and Address of Facility Adams Family Funeral Home, P.A. de 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ADENOCARCINOMA disease or condition resulting in death) TRI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical ding use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atten for u Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Cher (specify) detached 1 ☐ Yes 2 ☐ No by the 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To tha Funaral Diractor: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ( AK) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) memoria Tobustiano Barrera 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 3 1 2004 Registrar

		1	For State Registrar	State of Ma	•	epartment of F Certificate of			neg. No. 0 0 4	29595
	Physicia		1. Decedent's Name (First, Middle, La	st) Mary	Blanco	,		2. Date of Dea	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv				r Location of Death	,	4c. County of Dea	
				art Hos	PitaL e (In yrs. last birti		Der lan	8 Date of Birth	Alleo	inthplace (State or Foreign
	Funeral Director		213-24-7442	1 □ M 2 2 7 . Ag		rs. Months Days	Hours Min.	(Month, Day	6, 1929	Maryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. toside City Limits
	e Mary	ctor	Maryland Al	legany			Midland		40. 000 - 4000 - 40	1 X Yes 2 □ No
	with th	i Dire	10e. Street and Number 14826 B	roadway S. W.		10f. Zip Code	21542		10g. Citizen of What C	.S.A.
36	be filed within 72 hours after death with the Maryland hal Hygiene. od other then "naturel", or items 23e or 28a-f show event, the Medical Ever it at must be putilized at	교	11. Marital Status  1 ☐ Never Married 2 A Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
2-00	72 hou nature	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usuat Occu (Give kind of work done	during most of works	ing	16b. Kind of Busines	s/Industry
121	within ene. then "	Completed by	Elementary/Secondary (0-12)	College (†-4or s	ō+)	`life. DO NOT use retire Tead	cher Assistant		S	chool
nd 2	be filed state Hygin of other event, I	Be	17. Father's Name (First, Middle, Las.	Bernard P. Kild	uff		18. Mother's Name		Maiden Sumame) arie Bowen	
Baltimore, Maryland 21215-0036	d 2 should be th and Mental 7 is marked of treumetic eve	7	19a. Informant's Name/Relationship	(Type, Print)		Mailing Address (Street		al Route Numbe	er, City or Town, State,	
e, M	ges 1 and 2 t of Health a If item 27 is or other tre		Manuel Blanc	o-Husband	20b. Place of	148 Disposition (Name of y, crematory or other pla		Date	dland,Md. 2154	
Mor	Pages nent of I ont: If its		1  Burial 2 □ Cremation 3  Surial 2 □ Cremation 3  Surial 2 □ Other (Special Special			y, crematory or other pla Gap Veterans C		September 02, 2004	Flintston	e, Maryland
Balti	permit. Pag Department Importent: eny injury c		21. Signature of Funeral Service Lice	ensee		22. Name and Addr Eichhorn			ne P.A. 8 Eas	t Main Street
			23a. Parti. Enter the disease, or cor shock, or heart failure. List only	mplications that caused y one cause on each li	the death. Do r	not enter the mode of dy	ing, such as cardiac	aconing, Mor respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a_ acu	7 m	yocadir		dim		Onset and Death  I hour
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):				9
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ords	require een sig hould b	eted !	Severe c	hronic		tructive	7			Probably 4 Unknown autopsy findings available
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of	Physicien: or this certificated director,	2	1 ☐ Yes Z☐ No 27. Manner of Death	28a. Date of Inj (Month, Da	ury 28b.	Time of 28c. Inju			dence 6 Other (Sphow injury occurred	pecify)
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	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical C	29a. Certifier TV Certifying I (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis and manner s	of examination ar	e, death occurred at the nd/or investigation, in my	time, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier	$\alpha$			nse number		29d. Date signed (Mo	
	3		30. Name and address of person wh	o completed cause of	death (Item 23a)		21244		8/31/	2004
	5		JESUS TAW MA	O. FROSTB	URC PL		TBURG A	nd. 2	1532	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  SFP 0 2		trar's Signature	A los	1			
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		1 - For Stata Registrar	State of Marylan		artment of F rtificate of		-	giene Reg. NG. () (		29596
Dhusis		1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month	eath Day	Year	3. Time of Death
Physic /Med		Helen	Maxine		Boorda		108	24	04	1307 P.M.
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Deat	h	4c. County	of Death	
		SACred MEAR	et HOSPITAL		Cumbi	erland		HLL	-LGA	iny
Funera		5. Social Security Number 6. So	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12/01/	th ay, Year)	Coun	
Director		214-10-1808	02	TIS.			12/01/	1921	Mar	yland
and		Usuel Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
Many!	ō	MD Alle	gany		LaVale					1 □Yes 2 No
the 1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Cour	ntry?
with 3a or	0	715 National H	ighway		215	0.2		USA		•
death me 2	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H		pecify Yes or No		e - Americ	
after after	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ØNo				o Rican, etc.)		ck, White,	etc.
ours a	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify	/: W]	hite
ILK IS-DUSO within 72 hours after death with the Maryland ene. than "natural; or itame 23a or 28a-f show he Madical Experiment: was be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup	ation during most of wo	tkina	16b. Kind of Bu	usiness/Ind	dustry
ithin ithin	npldu	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	)	3			
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ed a b	Be	17. Father's Name (First, Middle, Last)	Adam	Siber	_			, Maiden Suman		
should be ind Mental simarked ournatic eve	ို	John				Laura		phine		erling
2 sh 2 sh and 1 sm		19a. Informant's Name/Relationship (7) Norma Howe / fri	** *		ng Address <i>(Street .</i> Sawmill L			•		(Code)
		20a. Method of Disposition			sition (Name of	ane, bed	Date P	20c. Location -		our State
00		1 🖾 Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crei	natory or other plac					
t. Partmentant:		' 4 □ Donation 5 □ Other (Specify			Mem. Gar					
permit. Page Department. Important: if any injury or once.		21. Signature il Funeral Service Licen		22		atur Str		•		Home, P.A. 21502
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		shock, or heart failure. List only	one cause on fach line.	_	2.5			rrest,		Approximate Interval Between Onset and Death
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/Medical Examiner		Toolskiing iii dodaiii,	Due to (or as a conseq	uence of):	Infar rcepho	todal	hu			Iday
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ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury								
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oo/ ificate g phys	edic		U							
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quires quires on sign							10	Yes all No	3 🗌 Prob	ably 4 Unknown
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g Physer this	L.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injun Worl			how injury occurr		,
SION C trending F death. tor: After the funera	atio	Natural 5 ☐ Pending 2 ☐ Accident investigation		полу		Yes 2 □No				
UNISION or Attending after death. Director: Afte	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and Numb	er or Rura	l Route Number,
ppitel or At ours after of eref Direct filled in by	Certification:		3,							
To the Hoepitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	wledge, death	occurred at the tin	ne, date and place	, and due to the	cause(s) and ma	inner as st	ated.
To the Hoe within 24 h To the Fun completely	led	one)	and manner stated.							
To	Σ	29b. Signature and title of certifier	hotani n		29c. Licens			29d. Date signed		
61	1	HIC	N	10	DSE	853		010	710	7
MIN		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print)	AVE C	UMBFI	RIANIA	MI	21502
1100		HABIB CHOTAN				, , , , ,			,	3
	tate trar	31. Date filed (Month, Day, Year) AUG 2 5 2004	32. Registrar's Signa	19	Spark					

			For State Registrar	• •	Department of Health and I Certificate of Death	Mental Hygiene	2010.
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, L Carrie Petty 4a. Facility Name (If not institution, gi	John Brown ve street and number)	4b. City, Town, or Location of Death		Yeer 1254 4M County of Death
<u> 44</u>	Funeral Director		5. Social Security Number 6.	Ilman Itaspital Sex 7. Age (In yrs. last 1 M 20XF 86	birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.		incess Georges  9. Birthplece (State or Foreign Country)  Delaware
	the Maryland	ector	Delaware Suss		own or Location Ford		10d. Inside City Limits 1 XYes 2 ☐ No
	er death with the trans 23a or 2 the man 23a or 2 the man 23a or 2 the man 2a	Funeral Director	10e. Street and Number 413 NE Front	<del></del>	10f. Zip Code 199 63	Unit	zen of What Country? Led States of america
5-0036	ral', or	d by Fune	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give A Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban Mexican, Puert		4. Race - American Indian, Bleck, White, etc. Specify: Black
21215-(	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. item 27 is marked other than "natural; other traumatic event, the Madical Exe	Completed by	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)		nistrater D	d of Business/Industry
Maryland	should be filed withir of Mental Hygiene. marked other than imatic event, the Mental Control of the Mental Con	To Be	17. Father's Name (First, Middle, Last Pett)	John	Geor	J	
	s 1 and 2 sho if Health and item 27 is my other traum		Norma Willia  20a. Method of Disposition	mS 20b. Place	of Disposition (Name of	tue Upper	Marboro MD 20772 eation - City or Town, State
Baltimore	permit. Pages Department of Importent: If it any injury or once.		1  Burial 2  □ Cremation 3   1  □ Donation 5  □ Other (Special Signature of Funeral Service Lice	ify)	22. Name and Address of Facility	-	Her Neck Delaware
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8760,	ate be executed thysician and the burial-transit	Jicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent of the consequent	Syllosofi; Arthy Di	STRATE	YEARS
P.O. Box 68	that the death certificate be executed by the attending physician detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2 Fetal de 4 Pregnant at time of death	ath 3 ☐Ectopic pregnancy	2	3d. Date of delivery Month Day Year
	w requires that the been signed by th should be detache	ed by PI		contributing to death but not resulting	ig in the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
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Division of	fing After fune	ation;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigate	( <i>Month, D</i> ay Yee <i>r</i> ) on	b. Time of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury	occurred
Divis	To the Hospitel or Attent within 24 hours after death To the Funeral Director:	Certification;	3 Suicide 6 Could not 4 Homicide determine		, farm, street, factory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	n 24 hou n 24 hou ns Funer	edicai	29a. Certifier  (Check only one)  (Check only one)  (Check only one)	Physician: To the best of my knowle- aminer: On the basis of examination and manner stated.	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause(s) arred at the time, date and	and manner as stated. place, and due to the cause(s)
•	To the Country of the	Z	29b. Signature and title of certifier	7	29c. License number	29d. Date	e signed (Month, Day, Year)
2	Ц ~		30. Name and address of person wh			~ 7	107/04
	T , 2 Sta	ite	Dr. Ophnell Cu 31. Date filed (Month, Day, Year)	mber Satch 841	<b>4</b>	Lover MD	20785
	Regist		SEPUS	2004 Blown S.	Goods		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Sept. 6, 2004 11:05 A George 01iver Buckler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Landover 1912 Barlowe Place Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 1920 Maryland 83 Director 216-12-4351 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If Itam 27 is marked other then "netural", or Items 23a or 28a-1 show ury or other traumatic event, Ita Medical Examinat must be notified at 1 □Yes X□No Director Maryland Prince Georges Landover 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe USA 1912 Barlowe Place 20785 Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Yes 2 No If Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Year or Dates:1940-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Caroline Estelle Buckler George Christopher Buckler ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Buckler - Wife 1912 Barlowe Place, Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Trinity Memorial Gdns 9-10-2004 Waldorf, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 21. Signature of Funeral Service Licensee M00053 A. aclo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE + EARG CONGESTIVE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YPER TENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Y*e*ar in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. by RENAC FAILURE CHRONG 1 Yes 2 No 3 Probably 4 Unknown ted Complete 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 2 2 No page certificate 1 ☐ Yes Division of Vital : After this certification and funeral director. or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 🗌 Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier 200 455 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 DRIVE S-SHIPMAN 5082 DORSEY HAU SYOIS CM, J. 3 -RANCIN E 31. Date filed (Month, Day, Year) SEP 0 8 State 2004 Registrar

			For State Registrar	State o	f Marylar		artment of				ene	20500
			Decedent's Name (First, Middle	e, Last)						. Date of Death	1	3. Time of Death
	Physici /Medi		Selma		C	ohen			A	Month ugust 3	1, 2004 Year	7:44 A M
	Examir		4a. Fecility Name (If not institution	-				n, or Location of			4c. County of Dee	th
			21736 Oscar H			In a A b Code of 1	Bushv		Od Hea		St. Mary	
\$	Funeral Director		5. Social Security Number 073–16–0494	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	82 Yrs.	If Under 1 Ye Months Day		Min.	Date of Birth (Month, Day,		thplace (Stete or Foreign buntry)
	D		Usual Residence of Decedent			04			J1	une 4,1	922 New	York
	arylan show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	88-f	ecto	MD Charl	es	Hu	ghesvi						1 ☐ Yes 2 No
	with t	Funeral Director	10e. Street and Number				10f. Zip Cod			10	g. Citizen of What Co	,
	leath ns 23	erai	6870 Barney Dr.		dent Ever in U	.S. 13.1	2063		inin? (Specif	y Yes or No-	U. S. A	
S	of the contract of the contrac	Fun	t ☐ Never Married 2 ☐ Marr	Armed For	ces?		Was Decedent of f Yes, specify C			an, etc.)	Black, Whit	
ğ	ral', c	1 by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Giv Year or Da	e ites:		1□Yes XX	No Specify:			Specify: Wi	nite
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23e or 28e-f show aumatic event, the Mudical Examinate must be notified at	Completed	15. Deceden (Specify only highe:	t's Education st grade completed)		16a. Deced (Give	dent's Usual Occ kind of work do DO NOT use ret	cupation ne <i>duri</i> ng mosi	t of working	1	6b. Kind of Business/	
7	within ane. then	mp	Elementary/Secondary (0-12)	College (1	-4or 5+)			- 1				
9	filed withi Hygiene. other ther		17. Father's Name (First, Middle,	Last)		Conti	acting				U. S. Gove a <i>id</i> en <i>Sumam</i> e)	ernment
an	id be ental ked o	To Be	Morris Moskow						a Kind		aldon obmano,	
ary	es 1 and 2 should to Health and Ment litem 27 is marked rother traumatics	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stre				City or Town, State, 2	Zip Code)
	1 and 2 Health a Gem 27 is		Marnie Grove /	Daughter		10					Maryland	
more,	of He		20a. Method of Disposition 1	3 Removal from S	20b. P	Place of Dispo semetery, cren	sition (Name of natory or other p		Date Septem	2	Oc. Location - City or	
Ē	Pages Iment of I tant: If its jury or o		`4 □Donation 5 □ Other (S				emetery		2, 200	)4 P:	rince Fred	erick MD
Balti	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service	Licensee	250.5	22	. Name and Add	dress of Facility	Brins	field-	Echols Fun	1. Hme.P.A.
	10240		23a. Part 1. Enter the disease, or	complications that are	MUC	0641 30	195 Thr	ee Not	ch Rd.	Charle	otte Hall,	MD 20622 Approximate
8760,	Physician /Medical Examiner  parial-transit	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (i	or as a consequence as a consequence or a consequence	uence of):	2018-2	elo	oce	luses		Interval Batween Onset and Death
P.O. Box 687	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		rth 2 ☐ Fetal unt at time of di	Ideath 3	Ectopic pregnar Other (specify)				23d. Date of delif	very Day Year
	es tha gned be de	by P	Part II. Other significant condition	ons contributing to de	ath bul not resu	ulting in the ur	iderlying cause	given in Part I.		23e. Did toba	cco use contribute to	the cause of death?
or o	requir sen si nould	ted	Myheime	Biseas	<u> </u>					1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Unknown
Vital Records,	The lay ate has page 2	Completed	COFD	2.00						24a. Was an autopsy performs	prior to c death?	topsy findings available ompletion of cause of
	nysician: nis certifica i director, p	o Be	25. Was case referred to medical examiner?	Hospital:	-			·		heck only one)		
ion of	Phy er this eral d	ertification: To	1 Yes 2 No  27. Manner Death 1 Natural 5 Pendin 2 Accident investig	28a. Date o (Mont/	patient 2 [] f Injury n, Day Yeer)	28b. Time of Injury	28c. In W	ury at fork?	28d.		ce 6 Other (Specinium occurred Lj	ify)Assisted Lving Home
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	200. Place	of Injury - At ho g, etc. (Specify	ome, farm, stre	et, factory, offic	8	28f.	Location (Stree City or Town,	et and Number or Rui State)	ral Route Number,
	the Hospi in 24 hou the Funer	edical	pne)	and mann	sis or examinal	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and opinion, deati	d place, and h occurred a	due to the caust the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To Con	Σ	29b. Signature and title of certifier	1			29c. Lice	nse number	0	29d	. Date signed (Month)	, Dey, Year)
_				111			10/	771	/	S	eptember 1	1, 2004
9	84		30. Name and address of person					Califor	mio 1	Mary 1 a-	d 20619	
	Sta	te	James C. Boyd 31. Date filed (Month, Day, Year)	32. Re	gistrar's Signal	ture	1	CallOI	iiid,	пагутап	u 40019	
	Registr		SEP 0	3 2004	Elec.	15 14	ARCH.					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BETHEL MAY CARROLL 9 2004 12:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ocean City Worcester 110 Yawl Dr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5/30/1927 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F Director 203-12-7963 77 PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director MD Ocean City Worcester 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code , or items 23a 110 Yawl Dr. 21842 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: White Specify: Completed by 3 Widowed 4 Vivorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Manager Restaurant 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Heart: If item 27 is marked off Charles W. Crider Bethle Krenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgette Metro 12913 Pine St. Ocean City, MD 21842 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9/7/04 1 Burial 2 remation 3 Removal from State injury or permit. Page Department of Important: If any injury or Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part1. Ent. The disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last C. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: esn. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 爲 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No page 2 certificate or Attending Phyaician: director. 25. Was case referred to medical examiner?
1 Tyes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of De th 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 🛣 No death. investigation 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person ted cause of death (Item 23a) (Type, Print) Lilah Gonzalez, M.D. 14 31. Date filed (Month, Day, Yea 32. Figistrar's Signature State 2004 Registrar

			State of Maryland / Department of He		-	_	
		4	For State of Maryland / Department of Her State of Maryland / Department of Her Registrar			. No.2 A A I.	20001
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	- <del> </del>	3. Time of Death
	Physicia /Medic		CATHERINE LAURA COULBOURNE		9	3 Year	1 2155 <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Death		4c. County of Dea	
			Atlantic General Hospital Berlin  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.   8	B. Date of Birth	Worces	
н	Funeral Director			Hours Min.	1/29/19	(ear) C	thplace (State or Foreign ountry)  MD
	D		Usuel Residence of Decedent		.,,		Teacher and the second
	arylan show	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 XYes 2 □ No
	he Ma	Director	MD Worcester Ocean Pines  10e. Street and Number 10f. Zip Code		100	. Citizen of What C	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tha Madical Examiner must be indiffed at	급	65 Ocean Parkway 21811			USA	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec	ify Yes or No-	14. Race - Am Black, Whi	
9	or Ite	F.	1 □ Never Married 2 Married 1 □ Yes 2 No 1 □ Yes 2 NO 1 □ Yes 2 NO 1	Specify:	ican, ctc.,		White
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15-	in 72 in mat	Completed	(Specify only highest grade completed) (Give kind of work done dur.	ring most of working	7	D. Kind of Business	windostry
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	al Hyg	Be C	Tr. I dated a state of the stat	8. Mother's Name (		iden Sumame)	
ylaı	should be filed within and Mental Hygiene.  s merked other than " umailc event, the Med	To I	Hoffard Truitt	Undyn			7.0.41
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and</i> 19c. Mailing A				
	1 and Healt Iem 2		20a Method of Disposition 20b. Place of Disposition (Name of	Da		c. Location - City o	
JOH.	Pages nent of h ant: If its ary or o		1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Pittsville Cemeter:		)4	Pittsville	, MD
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be intitified at Once.		21. Signature of Funeral Service Licensee	of Facility The	Burbage	e Funeral	Home
8	88 = 88		1 Michaeline : 1 Machay 108 William	St. Beri	in, MD	21811	
A.			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart allure. List only one cause on each line.	such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Hiseas	L_		
Ric.	/Medical Examiner		Due to (or as a consequence of):				
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	fin			
60,	be executed sicien and burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
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Box 6	death certificate I attending physi I for use as the b	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant			23d. Date of de	elivery
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P.0	es that the deathigned by the atte	hys	9 ☐ Unknown				
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Records,	w requires been sign should be	Completed			-		
3ec	has has	Idm			24a. Was an autopsy perform	prior to	
la		မ Co	25. Was case referred to medical	26. Place of Death			s 2□No
of Vital		To Be	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other		- Contract	ce 6 ☐Other (Sp.	ecify)
υot		T:U	27. Manner of Death 1	at 28	8d. Describe how	injury occurred	
Sior	Attending or death.	catlc	2 Accident investigation M 1 Ye	es 2 No			
Division	or Att	ertification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	21	City or Town.		Rural Route Number,
	spital ours a neral I	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time,	, date and place, ar	nd due to the cau	ise(s) and manner a	is stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	nion, death occurre	d at the time, dat	e and place, and du	e to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title ovcentribr 29c. License r	number		d. Date signed (Mor	
				0535	X	Plembe	4,2004
2	ET 2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	UD 25	011		
		ate	Dr. Nadia Angov 9733 Healthway Dr. Berlin  31. Date filed (Month, Day, Year)  32. Rygistrar's Signature	, MD 21	811		
	Regist		31. Date filed (Month, Day, Year) SEP 0 8 2004 32. Registrar's Signature				

DHMH 17 Rev 1/2001

55#216-05-6586 9/3/64 21155

Catherine Coulbourne

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** September Marian Eugenia Cowger 2004 1:00 m /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3070 Wooster Drive Bryans Road Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Fountry) | North Day | 10,193 | 5 | West Va. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2□₹ Yrs 69 235-46-7221 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Exercises. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 XNo Director Maryland Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3070 Wooster Drive 20616 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Schhol Bus Driver Charles County 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Z. Cutlip Idra Carnifax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3085 Wooster Dr., Bryans Road, Md. 20616 Karen Beattie Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 11, 2004

Mountain View Cemetery 20a. Method of Disposition

14 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Richwood, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Williams Funeral Home, P.A. 2064
42/0 Hawthorne Rd., Indian Head, Md. 21. Signature of Funeral Spice Licensee M00668 23a. Part 1. Enter the diseas A or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between CARCINOMA OVARIAN Onset and Death Immediate Cause (Final 6 Mo **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause E. La U. Ger ying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ VEIN THROMBOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 ☐ Yes Z No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death After 12 Hatural 5 Pending investigation death, 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBER 08 2004 de DI address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and J. PATEL 102 KAULMELLON CT WALPORF MD 20602 ASHVINKUMAR gistrar's Signature 0 8 2004 State Registrar

			State of I		epartment of H Certificate of I		-	giene Reg. No.?	11.	29603	
	Physici		Decedent's Name (First, Middle, Last)  Sallie Bird Dunkle				2. Date of De Month	Day	Year	3. Time of Death 06:00 AM	
10	/Medid Examir		4a. Facility Name (If not institution, give street and numb	er)	4	b. City, Town, or Lo				00,00 7 11 11	-
			Frostburg Village Nursing Care			Frostburg		Alleg	lany		
	Funeral Director		5. Social Security Number  212-34-6771  Usual Residence of Decedent  6. Sex  1 M 2 A F  7.	75 Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 15-Sep		9. Birthpl Count <b>Ken</b>	ace (State or Foreign ry) tucky	1
	/land		10a. State 10b. County	10c. City, Town	or Location				10	d. Inside City Limits	
	e-f sh	ţ	Maryland Allegany	Frostbur	α					1 Yes 2 □ No	
	iff the	Director	10e. Street and Number 26 Broadway		10f. Zip Code			10g. Citizen of V	Vhat Count	ry?	_
	s 23e	rai			21532-			U.S.A.			
020	ours after de ai', or item Examiner	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ☑ No	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	spanic Origin? (Spanic Origin?)  n, Mexican, Puerto  Specify:	ecify Yes or No Rican, etc.)	- 14. Race Blace Specify	e - America ek, White, e	tc.	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or items 23e or 28e-f show any highry or other traumatic event, the Medical Exarchment health and once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40)	or 5+)	Decedent's Usual Occupa Give kind of work done of life. DO NOT use retired	urina most of worki	ng	16b. Kind of Bu	isiness/Ind		
פַ	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)		- Jucon	18. Mother's Name	(First, Middle,				_
<u>ylar</u>	should by	To E	Arthur Vandevert			Martha S	hadburne	Whitcon	nb		
Jar	2 short and Is me		19a. Informant's Name/Relationship (Type, Print)	2.	Mailing Address (Street a	and Number or Rura	l Route Numbe	er, City or Town,	State, Zip (	Code)	
	1 and Health em 27		John L. Dunkle, Jr. husbo	unu	Disposition (Name of	Fros	tburg Date		yland	21532-	_
Baltimore,	Pages ment of I tent: If ite		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ite cemetery,	crematory or other place and Crematory			Cumberl	-		
Bal	pemit. Page Department of Importent: If any Injury or		21. Signature of Funeral Service Licensee	d	22. Name and Addres  Durst Funeral		rost Ave.	. Frostburg	, MD 2	21532	
			23a. Party. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do no	t enter the mode of dying	, such as cardiac o	r respiratory ar	rest,		Approximate nterval Between	
1	Physician /Medical			ndimo					-	Onset and Death 7 days	
	Examiner	<u>_</u>	resulting in death) a	Due to (or as a co						-	-
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о. О	The law requires that the death cei ate has been signed by the attendir page 2 should be detached for use	Phys								bly 41 Unknown	
Division of Vital Records,	signe signe d be c	d b	Service	23/1/2		unre	04- 141		Odb Mor		
ဂ္ဂ	w require been si	lete	Severe COPD. Conge Severe Chronic Rene	al Failu	re. Hyper:	tensron	24a. Was a perfor		avail com	e autopsy findings able prior to pletion of cause	
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<u>E</u>	ien: ortifica ctor, p	Bec	25. Was case referred to medical examiner?			26. Place of Death					-
2	hysic his ce al dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpa		atient 3□ DOA Othe	4 Nursing Hon	ne 5□Resid	ence 6 □Othe	r (Specify)		
ב	iing P	ion:	27. Manner of Death 1  Natural 5  Pending (Month, L	njury 28b. Tin Day Year) Inju	ıry Work		8d. Describe h	ow injury occurre	ed		
<u>  S </u>	Attencr deatl	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of I	Injury - At home, farm		es 2 No	8f. Location (S	treet and Numbe	r or Rural F	Route Number.	_
É	To the Hospital or Attending Physicien: with 24 hours after death: To the Funeral Director: After this certifical completely filled in by the funeral director; p	Certification:	4 ☐ Homicide determined building,	etc. (Specify)	, street, factory, office		City or Tow	n, State)	,		
	Hospi 24 hou Funer Funer stely fil	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the besis and manner.	of examination and/o	leath occurred at the time or investigation, in my opi	e, date and place, a nion, death occurre	nd due to the c d at the time, d	ause(s) and mar ate and place, a	ner as stat	ed. ne cause(s)	
	othe othe omple	Me	29b. Signature and title of certifier	Stated.	29c. License			9d. Date signed			-
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7	y LS		30. Name and address of person who completed cause of $S, L, Sandhir, M.D.$	death (Item 23a) (Ty	(pe, Print)  Tarn  Anak	erre	Fras	thur	MI	21537	
	Sta Registr			strar's Signature	1	,	,	7	/		_

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Jean Elliott September 2, 2004 2:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14112 Royal Oak Drive Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/17/1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 79 **Director** 220-16-6044 Maryland Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itama 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No by Funeral Director PA Bedford Bedford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 657 Pine Ridge Road 15522 USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Tire and Rubber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Mental Harold Wilson Valentine Pages 1 and 2 should ٩ Lula Mae Knippenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14112 Royal Oak Drive, Cumberland, 10 21502 of Disposition (Name of Date 20c. Location - City or Town, State Harold W. Elliott /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition to 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of important: if any injury or once. 4 Donation S Other (Specify) Union Cemetery 09/05/2004 Centerville, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 101 4ean /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy been signed by the attershould be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2 No 1 Yes 2□ No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify Residence Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Medical Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To tha Funerel Director: 2 Accident the 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \tag{Homicide} Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) D36766 September 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Seton Drive, Cumberland, MD Vik Poonai, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature books Registrar SEP 0 3 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month Year Ernest Joseph Femi August 21, 2004 11:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 14101 Winchester Road, S.W., Lot J Allegany Cresaptown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1**Z**M 2□F 213-44-1915 59 Yrs. Director 30-May-1945 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits rthan "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at Maryland Allegany 1 Yes 2 □ No Director Cresaptown 10e. Street and Number 14101 Winchester Road, S.W. 10f. Zip Code 10g. Citizen of What Country? 21505-Garden City Trailer Park Lot J U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after nd Mentat Hygiene. marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No ģ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer concrete pipe maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 Is marked oth Ernest Femi Wilma McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14101 Winchester Road, brother James Femi Cresaptown Maryland 21505-S.W. or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Finzel Cemetery 24-Aug-2004 Finzel \*4 □Donation 5 □ Other (Specify) Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ademocorainono **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2)X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f 25. Was case referred to medical examiner?

1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2/ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds New 0701 lan Jesus 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 3 2004 Registrar

			1 - For Stata Registrar	State of Marylan		artment of H tificate of L			iene () () L	29606
			1. Decedent's Name (First, Middle, Last)				· · · · · · · · · · · · · · · · · · ·	2. Date of Deat	h	3. Time of Death
	Physici /Medic		Joseph John G	arone				Month Sept	Day Year 2 2004	12:20pm <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of Dea	ath
			5330 Wesley R			Rhoesd			Dorche	
	Funeral		5. Social Security Number 6. Sex 141 07 2745	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		7.0.			03/12	2/1916 M	aryland
	yland		10a. State 10b. County	i	ty, Town or Lo			<u> </u>		10d. Inside City Limits
	Mar al	tor	MD Carol	ine l	Federa	alsburg				1 XYes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		16	g. Citizen of What C	Country?
	ath w 23a		1108 Routzahn	Lane		216	32		USA	
	er de	Funeral		<ol><li>Was Decedent Ever in U Armed Forces?</li></ol>	.S. 13. \	Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	
36	', or i	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 <b>⊠</b> Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Majical Exeminermust te notilited at		15. Decedent's Educ		16a. Deced	tent's Usual Occupa	ation		16b. Kind of Busines	s/Industry
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pu	0 = ->	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	faiden Sumame)	
yla		ပ္	John Garone				Mary Lo	pardo (	Garone	
Maryland	2 8 8 5		19a. Informant's Name/Relationship (Typ	e, Print)	ALCOHOL:	0.01 55			City or Town, State,	
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nor	Pages nent of h ant: If its ury or of		1 ☐ Burial 2  Cremation 3 ☐ Re	moval from State	cemetery, cren	natory or other place ate Conc	θ)		lontclai	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>			. Name and Addres		704	TOILCIAL	I NJ
Ba	permit. Departr Imports any inju		Muhael 7. Esk					N.Main	St. Fed	21632
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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Ш		Je .	Sequentially list conditions, b.	Athero Sc	lerot:	ic Heart	Diseas	e		Years
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Hypertent	ion					Years
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58760,	ficate be executed physician and s the burial-transit	dical	d.							
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Вох	death certifi e attending p id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	<ul> <li>c. If yes, outcome of pregnant</li> <li>1 ☐ Live birth 2 ☐ Feta</li> </ul>	ıl death 3□	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
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Δ,	th be		Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds,	uires sign ld be	d by								Probably 4 Unknown
Record	w require been si should t	Completed						24a. Was ar	24h Were a	utopsy findings available
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Vital		O	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 h Check on one		s 2 No
¥ <	d is	To B	examiner? 1 ☐ Yes 2 🖼 No	ospital: 1   Inpatient 2	ER/Outpatien	t 3 DOA Othe		me 32 Reside		SISTER, S
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Division	fter fter jira in b	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specil	ome, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number or F State)	Rural Route Number,
	ours a		29a. Certifier 1 Certifying Physi	cian: To the best of my kno	wledge doct	nonurrad at the time	o date and also-	and due to the	uea/a) and minimum	as stated
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	ation and/or inv	estigation, in my op	inion, death occur	red at the time, da	te and place, and du	e to the cause(s)
	To t To t	2	29b. Signature and Ale of Certifier			29c. License	number	29	d. Date signed (Mon	th, Day, Year)
•			July or of	Attending	MD	D0053	3094	09	9/03/04	
			30. Name and address of person who cor				21622			
	- 21		321 Bloomingdal	e Ave. Fed		ourg MD	21032			
	Sta Registi		31. Date filed (Month SEP 0 9 2	004	K A	docuts)				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

MUGUST 25 2004°

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

months

Month

Day

Towson, Md. 21204

Year

XXYes 2 No

NEW YORK

1:53 A M

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1 - For State Registra

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

4a. Fecility Name (If not institution, give street and number)

PAUL GRABOFF

32. Registar's Signature

172004

			1 - State Registrar	State of I	Marylan	-	artment of H		d Mental Hy	giene Reg. No.	101	29609
	Dhusisi		1. Decedent's Name (First, Middle, Last						2. Date of De.		Year	3. Time of Death
	Physici /Medic		PAUL DANIEL	HAENFT					AUGUST	30	2004	1025 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give		er)		4b. City, Town, or		eath		unty of Death	
			MEMORIAL HOSPIT  5. Social Security Number 6. Se		Age (In yrs.	last hirthday)	CUMBERI If Under 1 Year	AND If Under 24	Hrs. 8. Date of Birt		LEGANY	place (State or Foreign
	Funeral Director		-	]M 2□F	66	Yrs.	Months Days		Min. (Month, Da APR • 2	1938	Cou	ntry) YLAND
	pu ,		Usual Residence of Decedent		10- 01-	-						
	shoy	5	MD ALLEGA	NTV		y, To <b>wn</b> or Lo MBERLA						10d. Inside City Limits 1X Yes 2 □ No
	28e-1	rect	10e. Street and Number	TA T			10f. Zip Code			10a Citizen	of What Cou	
	3a or	Funeral Director	81 GREENE STREET				21502			U.S.		illay:
	death	nera	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.		Vas Decedent of Hi	spanic Origin	? (Specify Yes or No	- 14.	Race - Ameri	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event. It Medical Economical the rolling and other traumatic event.	by Fu	Never Married 2 Married  3 Widowed 4 Divorced	1 Tes 2	No No		iYes, specify Cuba I□Yes 2XINo	Specify:	uento Hican, etc.)		Black, White, ec <i>ify:</i> WHI	
21215-0036	72 hou	ted	15. Decedent's Edi	ication		16a. Deced	lent's Usual Occupa	ation	working	16b. Kind o	of Business/Ir	ndustry
2	ithin "e	Completed	Elementary/Secondary (0-12)	College (1-40	or 5+)	life. I	OO NOT use retired	)	working	DDG		***
72	filed w Hygier other ti		11 17. Father's Name (First, Middle, Last)			CUS	TODIAN	19 Mothodo	Name (First, Middle,		STAURAN	
Maryland	d be f	) Be	THEODORE WALTER H	אד. דיישואש בו	iC.				RINE MCGR		пате)	
Z.	2 should be and Mental is marked craumatic ev	ဥ	19a. Informant's Name/Relationship (T		••	19b. Mailir	g Address (Street a		r Rural Route Numbe		wn, State, Zij	o Code)
	1 and 2 Health a tem 27 is	,	JEAN MORGAN / SIS	TER		701	MCKINLEY	AVENUE	, CUMBERL	AND, M	4D 215	502
altimore,	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other <u>once</u> .		20a. Method of Disposition  1 Burial 2 Cremation 3 .  4 Donation 5 Other (Specify		te SUN	lace of Dispo emetery, crer SET ME	sition <i>(Name of</i> natory or other place MORIAL PA	RK 09/	Date 03/2004		ion - City or To BERLANI	
Balti	permit. Departminimporta		21. Signature of Funeral Service Lice	9000	heno	\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	Name and Addres	s of Facility UNERAL	HOME, P.	A.	MD 21	E02
•-			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus	sed the death						MD 21	.502 Approximate
Щ	Physician		Immediate Cause (Final disease or condition			RDTAT.	INFARCTIO	N				Onset and Death
	/Medical Examiner		resulting in death)	u	as a conseq		-11211110110					3 DAYS
Ш	LAdimines	_	Sequentially list conditions,	b	as a consequ							
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate outs. Error Unit 1975, Cause (Disease or injury	200 00 (01	as a consequ	uerice orj.						
Ć.	cate be executed physician and the burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):						
8760,	ate be nysicia he bui	dicai		d								
9	artifica ing ph e as th	Med	IF FEMALE:							-		
.O. Box	that the death certific led by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d.	Date of delive Month	ery Day Year
o, O	res that igned b	by P	Part II. Other significant conditions co	ntributing to deat	n but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use o	contribute to t	he cause of death?
ord	v requires been signi should be		POLYMYOSITIS	<u></u>					1 🗆 Y	es 22N	o 3 ☐ Prot	oably 4 □Unknown
Records	elaw hasb je 2 si	Completed		<u> </u>								opsy findings available mpletion of cause of
Vital	yaician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place of	Death Check onl o			
of V	S S	9	1 ☐ Yes 2 Z No	Hospital: 1 Inp		ER/Outpatien		4 1401311	ng Home 5 Resid			<b>(y</b> )
	ling P	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	Work	.7	28d. Describe h	ow injury oc	curred	
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e, Place of	Injury - At ho	ome, farm, str	eet, factory, office	res 2 □ No	28f Location (S	Street and Ni	umber or Run	al Route Number,
<u>S</u>	after after Dire	Certification:	4 Homicide determined		etc. (Specify		out, ladioly, dilloo		City or Ton	m, State)		ar riodio riamber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the be iner: On the basis and manner	s of examina	wledge, death tion and/or in	n occurred at the time restigation, in my op	e, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and date and place	I manner as s ce, and due to	tated. the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	1		0	29c. License	number	1		gned (Month,	
	2		Mobustiano	1 Jan	My	2	D1486	55		406.	301	+, 2004
	6.3		30. Name and address of person who o					CIIMDED				
	Sta	ite	ROBUSTIANO BARRER  31. Date filed (Month, Day, Year)		SUU ME		AVENUE	COMBER	LAND, MD 2	1302		
	Regist		SEP <b>0 3</b> 20				Spork	11				
DU	1.41.42.2	004	OLI OUZ	,51	-	~	- work	1				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	larylan			nt of H		and Mer		ene g. No.2 0 0 1	, 2960	10
	Dhoois		Decedent's Name (First, Middle, Las	1)							Date of Death	1	3. Time of De	ath
	Physici /Medic		ROBERT GEORGE HAI								ptembe	r <sup>Day</sup> , 200		MM
	Examir	er	4a. Facility Name (If not institution, give		)				Location o	of Death		4c. County of D		
	Funeral		17645 Entzian Pla 5. Social Security Number 6. Se		ge (In yrs.	last birthday)	If Und	ighesv er 1 Year	If Under a		Date of Birth	Charles 9.	Birthplace (State or Fe	oreign
. "	Director		152-22-7153	ZM 2□ F	76	Yrs.	Month	Days	Hours	Min. DE	(Month, Day, C 11,	Year)	w Jersey	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City L	imits
	Maryli f sho	tor	Maryland Charles			Huho		11e					1 <b>∑</b> Yes 2 [	
	3e or 28e	il Director	10e. Street and Number 17645 Entzian Pla	ace				ip Code 2063	7		10	g. Citizen of What	: Country?	
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Itama 23e or 28e-f show event, I're Medical Examinat must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Armed Forces 1 ∑ Yes 2 ☐ If Yes, Give Year or Dates:	?		f Yes, sp	edent of Hi ecify Cuba 2X No	spanic Orig n, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)		merican Indian, thite, etc. White	
P	2 hou atura	ted	15. Decedent's Ed	ucation		16a. Deced	dent's Us	ual Occupa	ation		1	6b. Kind of Busine	ess/Industry	
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)					of working				
21	filed wi Hygien other th		12 17. Father's Name (First, Middle, Last)			US Ar	med	Force		4. 11		ational	Security	
and	ed also	Be	Francis John Henry	/ Hartle							rst, middie, m ce Har	laiden Sumame) +1e		
2	should be and Mental marked o	2	19a. Informant's Name/Relationship (7			19b. Mailir	ng Addre					City or Town, Stat	e, Zip Code)	
Ž	alth a		Robin L. Fairchile	d (Daught	er)						esvill		0637	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 is marke any injury or other treumatic 8068.		20a. Method of Disposition  1 Burial 2X Cremation 3	Removal from State	1 -	Place of Dispo	sition (N	ame of other place	θ)	Date	2	Oc. Location - City	or Town, State	
Ĕ	Pages tment of I tent: If its		*4 ☐ Fonation 5 ☐ Other (Specify	)		ropoli	tan	Crema	atory	9-4-0	4 A1	exandria	, VA	
Ba	permit. Page Department: Importent: It any injury o		21. Signature of Funeral Solvice Licens	en	_	4	433	White	Pls	. La.	White	neral Se Pls., MD		
-04g			23a Pirt1. Enter the disease, or comp mock, or heart failure. List only of	lications that cause one cause on each	d the deat line.	h. Do not ent	er the mo	ode of dying	g, such as	cardiac or re	spiratory arre	st,	Approximate Interval Betwee Onset and Dea	in ith
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	<u> </u>		arlinous	u of	who	was br	runary !	s.te		3 morth	
	Examiner	ŀ	214 - 117-11 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 - 177 -	Due to (or as	s a conseq	(uence of):								
	~ ~ *	ner	fany, leading to immediate cause. Enter Underlying	Due to (or as	s a conseq	uence of):								
	cate be executed obysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Dup to /or or										
8760,	be ex ician a burial	al E		Due to (or as	s a conseq	uence or):								
687	ficate phys s the	edical		d.										
Box (	leath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			De-					23d. Date of	delivery	
о. В	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic Other (	pregnancy specify)				Month	Day Year	г
٥.	that the de led by the a detached		Part II. Other significant conditions co	entributing to death	but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did toba	acco use contribute	e to the cause of deat	h?
rds	quires tha n signed uld be det	ed by									1 PYes	s 2□No 3□	Probably 4 Dunki	nown
000	aw requir s been si 2 should	Completed									24a. Was an	24b. Were	autopsy findings ava-	ilable
ž		mo:									autopsy perform 1 Yes 2			3 Of
/ita	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?					120			neck only one			
of \	Physic this c	2	1 Yes 25 No	Hospital: 1 Inpat		ER/Outpatien	-		4 🗀 Nui		-	nce 6 Other (S	pecify)	
LO	ding Ph h. After th funeral	tion	1 Natural 5 Pending	28a. Date of Inj (Month, Da	ay Year)	Injury	М	28c. Injury Work	at ? /es 2 □ N		Describe nov	v injury occurred		
Division of Vital Records,	I or Attending Physicien: after death. Director: After this certifics I in by the funeral director, I	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	ijury - At ho itc. (Specif	ome, farm, str y)				281.	Location (Stre City or Town,		Rural Route Number	,
-	Hospite 4 hours Funerelt	edical C	29a. Certifier Check only one)	rsician: To the besi iner: On the basis and manner s	or examina	owledge, death	occurre vestigation	d at the tim	e, date and inion, deat	d place, and o	due to the cau t the time, dat	use(s) and manner te and place, and c	as stated. due to the cause(s)	
	To the within 2 To the complei	Me	29b. Signature and title of certifier				2	9c. License	number		29	d. Date signed (Me	onth, Day, Year)	
			ratter					D 2	1509		-	September	3 2004	
	2 1.10	Manage of the last	30. Name and address of person who o	completed cause of	death (Iten	п 23а) (Туре,	Print)	)		. (	MY	70170		
1	AVI de		Kenneth L. Albort  31. Date filed (Month, Day, Year)		rar's Signa		wite !	10 14	incl to	ex. L	. 110	20611	<del></del>	
*	Sta Registi		SEP 0.8	2004	en a signa	K. A	Local	60			_			

			1 - For State Registrar	State of Marylar				Mental Hyg	-	29610
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat		3. Time of Death
	Physici /Medio		Stanley	Owens	На	rtman		Month August	Day Year 28, 2004	1:50 A M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	, or Location of Death		4c. County of Death	
			11647 Bierman I	rive, S.E.		Cu	mberland		Alleg	anv
	Funeral		5. Social Security Number 6. S	3.7	last birthday)			8. Date of Birth (Month, Day,		place (State or Foreign
	Director		218-16-4614	ØM 2□F 79	Yrs.	Months Day	s Hours Min.	04/05/1	925 Mary	land
	P .		Usual Residence of Decedent							
	nylar how	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	in the	cto	MD All	egany	Cum	berland				1 ☐ Yes 2Ã No
	or 26	lre	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	intry?
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show then "naturel", or item as 15e notified at	Funeral Director	11647 Bierman I	rive, S.E.		21	.502	Ī	USA	
	dea .	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of	Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White	
စ္	or it	F	1 ☐ Never Married 2 ☐ Married	1 XYes 2 No194 If Yes, Give	3 - 1	1 □ Yes 2 N		, , , , , , , , , , , , , , , , , , ,		
21215-0036	ref.	d by	3 X Widowed 4 ☐ Divorced	Year or Dates: 194	6	10103 2010	o specify.		Specify:	White
V	72 h natu	etec	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occ	upation e during most of wor	kina	16b. Kind of Business/l	ndustry
7	ithin	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	1		ne during most of won red)			
N	filed w Hygier other then	Completed	9			Conducto			Railroad	
ם	tal Hydoth	Be	17. Father's Name (First, Middle, Last,					ne (First, Middle, M		
<u>a</u>	should to a marked umatic	၉	Ernest Ed	lwin	Har	tman	Bertha	Vio	ola Bie	rman
**	01 00 00		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Stree	et and Number or Ru	ral Route Number,	City or Town, State, Zi	p Code)
	1 and 2 Health tem 27		Bertha V. Rosboro	ough / daughte	r 116	45 Brehm	Road, S.	E., Cumbe	erland, MD	21502
Š	of He		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	1	Place of Disponentery, cree	sition (Name of matory or other p	/ace)	Date	20c. Location - City or T	own, State
altimore,	Pages nent of ant: if its ary or o		`4 □Donation 5 □ Other (Specif	1 0	mberla	nd Crema	tory   08/2	28/2004	Cumberlan	d, MD
፷	mit.		21. Signature of Funeral Service Licer	isee	22	2. Name and Add	ress of Facility A	lams Fam	lly Funeral	Home, P.A.
m	permi Depa Impo any ir		I fullet (	Culana		404 Deca	tur Street	t, Cumber	rland, MD	21502
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	plications that caused the dea one cause on each line.  a. AVENOC  Due to (or as a consect to the consect to th	ARC quence of):				est,	Approximate Interval Between Onset and Death
8760,	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be delached for use as the burial-transit	dicai Examiner	causé, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consec	quence of):					
P.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6 9 ☐ Unknown	aldeath 3	Ectopic pregnan Other (specify)	cy		23d. Date of deliv	ery Day Year
	that ed b deta	P	Part II. Other significent conditions of	ontributing to death but not res	sulting in the u	nderlying cause g	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	uires sign	d by						1 🗹 Ye	s 2□No 3□Pro	babiy 4  Unknown
ğ	been shou	Completed								
ĕ	e law has	ldπ						24a. Was ar autops perform	y prior to co	opsy findings available empletion of cause of
=	. The	õ							death?	2 No
ij	cien: ertific	Be	25. Was case referred to medical examiner?					h (Check only one	9)	
$\leq$	hysi his c	2	1 ☐ Yes 2 ☑ No		ER/Outpatier	IL 3L DOA	ther: 4 Nursing H	ome 5 Reside	nce 6 ☐Other (Speci	fy)
2	ng P fter t	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inj	ury at ork?	28d. Describe ho	w injury occurred	
Š	Attending r death. ector: After by the fune	ath	2 Accident investigation			M 1[	□Yes 2□No			
Division of Vital		Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office	9	28f. Location (Str City or Town	eet and Number or Rur , State)	al Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exer	ysician: To the best of my kniner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as a te and place, and due t	stated. o the cause(s)
	withi To 11	ž	29b. Signature and title of certifier	. /		29c. Licer	nse number	29	d. Date signed (Month,	Day, Year)
(II	)		Al Sunta	2 1 1/Sex	nes (	/ n-	14865	A	106. 28	2004
(h)	Gratis		30. Name and address of person who	completed cause of death (Ite	n 23a) (Tvo	Print)	1 . 0 4		,	
V	NOB		Robustiano J.			•	al Avenue,	Cumberl	land, MD 2	1502
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Son		uls			<del>_</del>	
	Registr		AUG 3 0 2004	LIENER	MUD	The same				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** AUGUST 28, 7:05 A BERNARD MORTON HILL 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LIONS MANOR NURSING HOME ALLEGANY CUMBERLAND If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Yrs. 82 PENNSYLVANIA Director 215-18-8683 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "neturel", or items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 27 No Funeral Director WV MINERAL RIDGELEY 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ROUTE 1, BOX 490 26753 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be itied within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or iten any injury or other treumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **CLERK** RAILROAD - CHESSIE SYS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT M. HILL KATHERINE KEIM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET HILL / WIFE ROUTE 1, BOX 490 - RIDGELEY, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State CUMBERLAND CREMATORY 08/30/2004 CUMBERLAND, MD ' 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic tumor one month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 2 No 1 ☐ Yes To the Hospitel or Attending Physician: : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: d in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Workslin 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1- U-A WONSOCK SHIN Terrace Frostburg MD 21532 48 Tarm 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SEP 0 1 2004

			For State Registrar	State of	Marylan		artment of F		nd Mental Hy	giene Reg. No.	100	296	512
			Decedent's Name (First, Middle,	Last)	-				2. Date of De	aath			of Death
	Physici /Medi		North		HUTC	ching			August	Day	/ Yea <b>2</b> ¢ <i>ε</i>		AM
	Examir		4a. Facility Name (If not institution,	give street and numb	er)		4b. City, Town, or	r Location of I	Death	4c.	County of De	eath	1
			University of Ma				Balto		H				
	Funeral		5. Social Security Number 214-32-9801	5. Sex 7. 1 ☐ M 2 ☐ <b>x</b> /F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, Di	rth ay, Year)		Birthplace (State Country)	
	Director		Usual Residence of Decedent	A					June9	,19	33   M.	arylan	d
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside	City Limits
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36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturei", or Itams 23a or 28a-1 show event, the Medical Examinar must be routiled at	by Funerai	11. Marital Status  1 □ Never Married 2 ★ Marrie  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force d 1 Tes 2 If Yes, Give	es? No		v	ispanic Origir In, Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)	o-	14. Race - Ar Black, W Specify: B		
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7	filed withi Hygiene. Ither than	Con	12				Secretai					Schoo	01
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Z	d 2 should be it and Mental I 7 is marked o traumatic eve	2	Peter	- (Time Driet)	1110111				lphine		Johns		
Ma	tra tra		19a. Informant's Name/Relationship Jeremiah Hutch		and		Box 97		or Rural Route Numb isby, MD			, Zip Code)	
	is 1 and 27 item 27 other tr		20a. Method of Disposition				sition (Name of natory or other place		Date			or Town, State	
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Baltimore,	permit. Page Department importent: If any injury or once.		21. Signature of Funeral Service Line Allaches A.	•	2				Sewell lach Rd.				020678
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau	sed the death	. Do not ent	er the mode of dyin	g, such as ca	rdiac or respiratory a	rrest,		Approxim	ate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Geps	as a consequ						10) <u>0</u> - 4	Interval B Onset and	d Death
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ő	te be executed ysiclen and e burial-transit		resulting in death) Last	Due to (or	as a consequ	ience of):							
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Records, P	uires that n signed b ld be deta	by	Part II. Other significant condition  Diabetes Mei		h but not resu	alting in the ur	nderlying cause give	en in Part I.		obacco u Yes 2[		to the cause of	
00	sw requir s been s should	Completed	Chronic Obstr	-	44.01.0	. 0	1.3.40		24a. Was	an	24b Were	autopsy finding	s available
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<b>\</b>	ysic s ce	To B	examiner? 1 ☐ Yes 2 <b>K</b> No	Hospital: 1 Inp	atient 2 🗆 8	ER/Outpatien	t 3 DOA Othe		ng Home 5 ☐ Resi		i □Other (Sp	ecify)	
n of	te te		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe	how injury	occurred		
SIO	Attending r death. sctor: After oy the fune	cati	2 ☐ Accident investiga	tion			M 1 🗆 '	Yes 2□No					
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	To the Hospital within 24 hours of To the Funeral I completely filled	Medical	(Check only 2 Medical E)	Physician: To the be caminer: On the basi and manner	s of examinati	ion and/or inv	estigation, in my or	oinion, death	occurred at the time,	date and	place, and de	ue to the cause	(s)
	So J wit	-	29b. Signature and title of certifier	,			29c. License			290. Date	signed (Moi	nth, Day, Year)	
7			X Srigit T	250 , 14D				5896		Ang	USF 31	,2004	
	6		30. Name and address of person was BRICHT TAYLOR		of death (Item ユーシンコ			FET	BALTIMORE				
	Sta	te	31. Date filed (Month, Day, Year)	32. Reg	istr s Signat	ure	1 1	,	DATE LE LOICE	, 1410			
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygions

				State of Mar		rtificate of		, ,	eg. No?	01. 3	00010
			1. Decedent's Neme (First, Middle, Last	)				2. Dete of Deet	th		Time of Death
	Physic		Mary Regina (	ohnson				Month SEPT.	Day 5 200	Year /	3:47pm
	/Medi Exami		4a Fecility Name (If not institution, give			-	4b. City, Town, or	Location of Death	4c. County		):4/pm
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	Funeral		5. Social Security Number 6. Se	x 7. Age (	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8 Date of Birth			(State or Foreign
	Director		214-14-0158 1D	<sup>] M</sup> X□ F 8	34 Yrs.	Months Days	Hours Min	Sept. 8	, 1919	Mary I	and
	iryland		10a. State 10b. County	1	0c. City, Town or Lo	ecation				1	Inside City Limits
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020	is 1 and 2 should be filad within 72 hours after death with the Maryland of Haalth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Evanricer must be notified at	To Be Completed by Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🛣 No		Specify Yes or No- to Rican, etc.)		e - American I ck, White, etc.	
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	othe vent,	Se C	17. Father's Neme (First, Middle, Last)		<u> </u>		18. Mother's Na	me (First, Middle, M			
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Mai	od 2 sh lth and 17 is m traum	ď	19a. Informant's Name/Relationship (T) Beverly A. Jarboe	11/25				u <i>ral Route Numb</i> er, ad, Hughe			
re,	of Haa Item 2		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Name of	COMIL IO		20c. Location -		
Baltimore,	Page ment c		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Old Field			9-9-04 H	lughesv	ille, M	ID
Ball	permit. Pages 1 and 2 Department of Haaith a important: if item 27 is eny injury or other tra		21. Signature of Funeral Service License  Hayle & Bu	≈ M00053		ntt Fune O. Box		dorf, MD	20604		
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ion	Attending For death.	ation	1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Ye	ear) Injury	28c. Injun Worl M 1 □	k? Yes 2□No	20d. Describe no	w injury occurr	<del>o</del> u	
Division	al or Atte s after des l Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (Str. City or Town,		er or Rural Ro	ite Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificata has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of mer: On the basis of exa and manner stated	amination and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and mar te and place, a	nner as stated and due to the	cause(s)
	Withi To th	Σ	29b. Signature and title of certifier		Q.	29c. Licenso	e number		d. Date signed		,
9			V. Mum	J.		D-26	064		09-6	6-2	2004
S	SB12		30. Name end eddress of person who co	mpleted cause of deeth NGANDLA M	(Item 23a) (Type, ID P.O.B	OX 282	CHARLOT	TE HALL	MD 20	0622	
14	Sta Registr		31. Date filed (Month, Day, Year) SFP 0.8.20	32. Figistrar's	2.0	asile					

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			Decedent's Name (First, Middle, Last						Ì	2. Date of Dea	th		3. Time	of Death
	Physicia /Medic		Clara Rebecca	Kennell						Month Sept 1	1 O	2004	9:3	0 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	Location o	f Death		1	. County of Death		0 21
			15007 Mt. Savag	e Road	NW	M	t. s	avag	е		A	llegany	,	
	Funeral		5. Social Security Number 6. Se		ge (In yrs. last bir	thday) If Unc	er 1 Year	If Under 2		8. Date of Birth (Month, Day				or Foreign
	Director		214-07-2453	☐M 21XF	92	Yrs. Month	Days	Hours	Min.	March	25	,1912Ma	™y) rvlar	hr
_	P		Usual Residence of Decedent		T.,							<del></del>		
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	Be-f	ç	Maryland Allega	ny	Mt.	Savage	}						1	s 21∑No
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	tems tems	by Funerai	11. Marital Status	<ol><li>Was Deceden Armed Forces</li></ol>	?	13. Was Dec	edent of Hi	ispanic Orig in, Mexican	gin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Americ Black, White,		
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2	hould d Me mark mati	은	19a. Informant's Name/Relationship (T	ivne Print)	195	Mailing Addre	ss (Street s			lbrigh		or Tourn State 7in	Codel	
Maryland	d 2 s th an 7 ls treui		Earl Kennell-S							2		or Town, State, Zip		
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Division of Vital Records,	tel or Attending Physicien: Tre after death. el Director: After this certificat ed in by the funeral director, pa	Certification;	4 Homicide determined	28e. Place of In building, e	njury - At home, fa etc. <i>(Specify)</i>	arm, street, facto	ory, office		2	8f. Location (Si City or Town		nd Number or Rura e)	I Route Nu	mber,
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	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai	29a. Certifier 1 Pertifying Phy (Check only 2 Medical Exam	iner: On the basis	of examination an	e, death occurre id/or investigation	d at the tim	ne, date and pinion, deat	d place, a th occurre	nd due to the c d at the time. d	ause(s ate an	and manner as st d place, and due to	ated.	(s)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death WCHD, CH Reg. No. Amend<u>ed Item</u> A, Per Physician, 9/2/04, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 31,2004 Ruth Chassie Lyle 10:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ~70 Martinique Gircle Berlin Worcester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director Tennessee 89 385-05-9396 July 27,1915 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f ehov any injury or other traumatic event, It a Medical Extra trust be triditive at MD Worcester Berlin Director 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 70 Martinique Circle 21811 US by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 □ Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charley H. Woody lda E. Rymer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Ford Bootsma 56 Lundy's Lane, Newmarket, Ontario, Canada, L3Y3R8 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 9-3-04 Berlin, Maryland of Funer 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 unla Part. Enter the disease, of complications that on shock, or hear failure. List only one cause on ear Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA this 5 Residence 6 □Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred al or Attending P s efter death. Il Director: After After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investination, in my opinion, death accurred at the cause(s) and manner as stated. Medicai 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) 104 314 FRANKLIN AVENUE SHITE MD 21811 legistrar's Signature 31. Date filed (Month, Day, Year) State

SEP 0 2 2004

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 2.5-72:20 04 /Medical <u>LaVern Jane Llewellyn</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SACRED HEART CUMBERLAND HUSPITAL ALLEGAN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Maryland Director 04-Jan-1926 <u> 216-22-7068</u> Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event. If a Medical Examinar must be notified at Yes 2 No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 74 Mt. Pleasant St. 21532-U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify White 1 ☐ Yes 2 1 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Is marked other then any injury or other traumatic event. It a Mean injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Geary Chester A. Lohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 74 Mt. Pleasant St. Edman Eugene Llewellyn husband 21532-Maryland Frostbura Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 29-Aug-2004 Frostburg Maryland Frostburg Memorial Park 21. Signature of Euneral Service License 22. Name and Address of Facility John I Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEDTI Cenu 2 days. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner transit The law requires that the death certificate be executed and Due to (or as a consequence of): physician a Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day ō Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably Completed SACRAL AREA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy Rheumatoid RVANGE ARTHRITIC 1 Yes 1□ Yes 2 No 2 🗌 No of Vital Be director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No 9 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 725638 M. 5 angust 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nas 10701 New George Creek S. W Frotburg Mary land 21532 SATURNIANS CHANG M.D. 32. Registrar's Signature 31. Date filed (Month, AUG 2 7 2004 State

Registrar

Amended #18, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08/19/04, Allegany Co. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** AUGUST 7, Leo F. Malloy
4a. Facility Name (If not institution, give street and number) 2004 1341 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Director 213-24-5547 Usual Residence of Decedent 17-May-1929 Maryland Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Allegany Mount Savage the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 15408 Iron Rail Street, N.W. 21545 Items 23e Pages 1 and 2 should be filed within 72 hours after death 1 thent of Health and Mental Hygiene.
 Herne 27 is marked other then "neturel", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) munitions manufacturer maintenance supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Annadelle Monahan 2 George Malloy Annadette Monahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15408 Iron Rail Street, N.W. other Joella Malloy Mount Savage. Maryland 21545-20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 □ Donation = 5 □ Other (Specify) Saint Patrick Cemetery 20-Aug-2004 Mt. Savage Maryland permit.
Departr
Importe
eny inju 21. Signature of Funeral Service Licen 22. Name and Address of Facility blen Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a ANOXIC ENCEPHALOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, b. HYPOTENSION Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed burial-transi DIABETES MELLITUS attending physician and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be ISCHEMIC CARDIOMYOPATHY 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC RENAL INSUFFCIENCY 24a. Was an page 2 autopsy performed2 2 No 2 No 1 Yes of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospitel 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) celh D0054411 AUGUST 17, 2004 30. Name and address of person who completed cause of death (Item 23a) pe, Print)

State Registrar DR.BEVERLY CALKINS

AUG 1 9 2004

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

oaks

500 MEMORIAL AVENUE

32. Registrar's Signature

CUMBERLAND, MD 21502

Amended #10e, nls, 08/23/04, Allegany Co.

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Dea		, ,	eg. No.	01, 2	0610
	Physici	an.	Decedent's Name (First, Middle, Last)  TDDNND     NAD DDD	2	. Date of Deat Month	h	Year 3.	Time of Death
	/Media	cal	IRENE MARGARET MORELAND		UGUST		2004 1	l:25 AM
1	Examir	ner		y, Town, or Loca CUMBERL		4c. County		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Ur		AND Date of Birth (Month, Day,		LEGANY  9. Birthplace	(State or Foreign
	Director		218–48–9505 77 Yrs.	J.	$AN \cdot 9$	1927	WEST VI	RGINIA
	and T		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Ir	side City Limits
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	ath wi	ral	#1 BALTIMORE STRET 21502			U.S	. A .	
21215-0020	d within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at the Medical Examiner must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No  If Yes, specify Cuban, Mex  I		y Yes or No- can, etc.)		ce - American In ck, White, etc. fy: WHI	
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	and 2 ealth n 27 I		CURTIS MORELAND / SON ROUTE 2, BOX 138					
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item 2 any injury or other once.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)				- City or Town, S	
Ħ	permit. Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License  22. Name and Address of Fi		20/2004	FOR'I	ASHBY,	WV
Ba	permit. Departrimports any inji		UPCHURCH FUI P.O. BOX 120	NERAL HO 60 – FOI	RT ASHE	BY,WV	26719	
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart editure. List only one cause on each line.	h as cardiac or re	espiratory arre	st,	Inter	oximate val Between et and Death
J. S.	/Medical		Immediate Cause (Final disease or condition a Metastatic Colon Cana	· · · · · · ·			(	4 V-
	Examiner		resulting in death)  a. Due to (or as a consequence of):	20000				(
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0	th. : After e fune	ition	27. Manner of Death  128. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2 □ Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work? 1 □ Yes 2		. Describe not	w injury occur	ieu	
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	mis		30. Name and address of person who completely cause of death (Item 23a) (Type, Print)  Suni   Gupta - 635   Kept Ave Cumberk  31. Date filed (Month, Day, Year)   32. Registrar's Signature			0		
			21 Date fled (Month Day York) 122 Desistant Signature	erd Mo	D 215	502		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3 2004  32. Registrar's Signatus					

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ledio amir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	7106	4c. County o	
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eral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Fore Country)
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40	}	Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limi
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event, the Medical Executer must be notified at	Funeral Director	Maryland Garret  10e. Street and Number 1025 Street		inzel	10f. Zip Code			log. Citizen of W	hat Country?
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Jer tr		James Marvin McKe				Fros	tburg	Maryl	
i of		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐		Ob. Place of Dispo cemetery, crea	osition (Name of matory or other plac	e)	Date		City or Town, State
njury o		* 4 □ Donation 5 □ Other (Specify		mmanuel M	ethodist Cem	etery 21-	Aug-2004_	Finzel	Maryland
any njury or other		21. Signature of Funeral Service Licens	-	2:	2. Name and Addres	ss of Facility			
a 0		John The	Kurry		ourst Funeral				
		23a. Port. Enter the disease, or composite only of the control of	dications that caused the one cause on each line.	death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
ian		Immediate Cause (Final disease or condition	acute	wy	OCATALI	al Info	ration		12 hear
cal ner		resulting in death)	Due to (or as a co	nsequence of):	Brien	0			
		Sequentially list conditions,	b. Coven	nsequence of):	1874cm	hisea	10		lecton
Ď	nju	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1304401,00 01).	,				
urial-transıf	Examine	that initiated events resulting in death) Last	cDue to (or as a co	nsequence of):					
buri									
Ø.	o di		d						
s E		IC CCLIAIC	23c. If yes, outcome of pr	egnancy				23d. Date	of delivery
use as the burial	Š	IF FEMALE:						Mon	
for use	cian/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		□Ectopic pregnancy □ Other (specify)			1	
for use	hysician/M	23b. Was decedent pregnant							
detached for use	y Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2□No	4 □ Pregnant at time 9 □ Unknown  ontributing to death but no	of death 5 [	Other (specify)		23e. Did to	bacco use contri	bute to the cause of death?
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rector, page 2 should be detached for use	Be Completed by	23b. Was decedent pregnant in the past 12 months?  1  Yes 22 No 9  Unknown  Part II. Other significant conditions of	4☐ Pregnant at time 9☐ Unknown	of death 5 [ of resulting in the unkertes n	Other (specify)	an in Part I.  26. Place of Deat	1 Yes	res 2 No an 24b. We say promed?	bute to the cause of death? 3 Probably Minknor fere autopsy findings availal itior to completion of cause of eath? No
al director, page 2 should be detached for use	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the part    4 Pregnant at time 9 Unknown	of death 5 [ of resulting in the under the second of the s	Other (specify)	an in Part I.  26. Place of Deat  er: 4 □ Nursing Ho	1 Y Y 24a. Was autop perior 1 Yes th (Check only or Residue)	res 2 No san 24b. W pr de de 22 No 1	bute to the cause of death?  3 Probably Inknoving availation to completion of cause cauth?  Yes 2 No	
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Certificate of Death

2. Date of Death

3. Time of Death

29d. Date signed (Month, Day, Year)

	Physici /Medic		DOROTHY MATI	LDA TARMAN	MILLE	R		SEPTEN	Day IBER	10 Yeer	004 4:20p
Ì	Examir		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	ath	4c. Co	ounty of Deat	h
	exam.	٠.	Chester River	Hospital Ce	nter	Chest	ertown		Κe	ent	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hr				hplace (State or Foreign
	Director		171-10-9058 1 1 Usual Residence of Decedent	□M 2対F 96	Yrs.	Wortins Days	Hours Will	Mar 12	190	)8 Mai	ryland
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	e Mary Se-f sh	ctor	MD Kent	S	till 1						1 □Yes 2 🔯 No
	or 28	Ji e	10e. Street and Number			10f. Zip Code			_	n of What Co	untry?
	th w	a	26120 Bessicks	Corner Rd.		2166	7		U.S.		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Exercities marked	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☆No If Yes, Give Year or Dates:		Was Decedent of Information of Info		(Specify Yes or No- erto Rican, etc.)		. Race - Ame Black, White pecify:	
215-0036	"natur	Completed by	15. Decedent's Ec (Specify only highest gra		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	oation during most of w	orking	16b. Kind	of Business/	Industry
12	within iene.	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker	-/		Own	Home	4
d 21	Hygin ther		17. Father's Name (First, Middle, Last)		1101	demaner	18. Mother's N	ame (First, Middle,			<u> </u>
an	ontal	Be C	James Brecken		n		Georg	ianna D	avis		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Ire IV	٦ ر	19a. Informant's Name/Relationship (			ng Address (Street		Rural Route Numbe			Zip Code) 21667
	and 2 alth a 127 ls		Franklin D. M				ssicks	Corner			Pond MD.
re			20a. Method of Disposition 1. X Burial 2 ☐ Cremation 3 ☐			sition (Neme of matory or other pla	ce)	Date	20c. Loca	tion - City or	Town, State
Ĕ	Page:		'4 □Donation 5 □ Other (Specifi		hester	Cemet	ery 9/	14/04	Che	stert	own, MD.
Baltimore,	permit. Page Depertment of Important: If any injury of once.		21. Signardie of Furtheral Service Licen	M005				Home of St. Gal			L. Schaech
	Physician /Medical Examiner		28a. Pert 1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Pinal disease or condition resulting in death)	plications that ceused the de one cause on each line.	ath. Do not ent Philipped equence of):	ter the mode of dyi	ng, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.)	equence of):						
68760,	te be ex tysician he burial			d							
Box 68	death certificate be executed e attending physician and d for use as the burial-transit	sician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe		Ectopic pregnanc	y		230	d. Date of deli	ivery Day Year
Ю. В	D 00 D	ysici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)				WORT	Day Teal
٩	that the sed by detac	Phys	Part II. Other significent conditions of	ontributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
rds,		ed by						101	′es 2. 🗹	Ño 3□Pr	obably 4 Unknown
of Vital Records,	The law r ate has be page 2 sh	Completed							an sy med? 2 No	death?	topsy findings available completion of cause of 2 12 100
/ita	cian: ertific	Be	25. Was case referred to medical examiner?	11 2. 1				eath (Check only o	ne)		
Ž	Physician: this certific al director,	ဥ	1 ☐ Yes 2 ♠No		ER/Outpatier	II JU DON		Home 5 Resid			pify)
ion o	ing Vite	ation;	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	Wo	ryat rk? ]Yes 2 □ No	28d. Describe h	iow injury o	occurred	
Division	Hospitel or Attendi 24 hours after death. Funerel Director: 4	Certification:	3 Suicide 6 Could not b determined		home, farm, sti	reet, factory, office		28f. Location (5 City or Ton	Street and t m, State)	Number or Ru	iral Route Number,
	Hospite 24 hours Funere	dical C		nysicien: To the best of my kinner: On the basis of examination							

1. Decedent's Name (First, Middle, Last)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Paul Donaher, M.D.

SEP 17 2004

31. Date filed (Month, Day, Year)

29c. License number

D0058824

119 C. North Main St. Galena, MD. 21635

			riease	Type of Pillit					•		gible.	
			For	State of Man	-	-			lental Hy	glene	2	
			Stete Registrar			Pertifica	ite of L	Death		Reg. No.	) () (,	29621
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De		-	3. Time of Death
	Physici		Mattie B	. Nibla	ett				Month	5 Day	Yeer	12:55 PM
	/Medic Examir		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	Location of Death		4c. Cou	inty of Deet	
	LAGIIII	iei	Atlantic 6	eneral t	toso to	1 1	3011,	1 Mar	Eland	1 .	orce	
	Francis 1		5. Social Security Number 6. S		In yrs. last birtho	(av) If Und	ler 1 Year	If Under 24 Hrs.	8. Date of Bir			
	Funeral Director			□M 2□XF 93	Yrs	Month	s Days	Hours Min.	6. Date of Bir (Month, Da Sept.	y, Year)	MD	hplece (State or Foreign untry)
m			Usual Residence of Decedent						sept.	10,1510	IVID	<u></u>
50	/land		10a. State 10b. County	1	Oc. City, Town o	r Location						10d. Inside City Limits
30	Man,	ō	MD Worceste	r	Ocean	City						1 ☐ Yes 2 🔀 No
i A	death with the Maryland ms 23a or 28a-f show r mast be notified at	by Funeral Director	10e. Street and Number		Occarr		Zip Code			10g. Citizen	of What Co	untry?
2000	With Sa or	0	9801 Golf Course	Rd.			218	11.2		US		•
20	eath	era	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Dec			ecify Yes or No		Race - Ame	ncan Indian,
710	iter d	5	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No		If Yes, sp	ecify Cubai	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	E	Black, White	
10 m	hours atter tural', or ite	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2X No	Specify:		Spe	city: Wh	ite
55#215 000 15-0036	hou	ed	15. Decedent's Ed		16a D	ecedent's Us	sual Occupa	tion		16b. Kind of	f Rusiness/	Industry
5	n 72 n nat	let	(Specify only highest gra	de completed)	(6	ive kind of v	vork done d	uring most of work	ring	TOD. KING O	Dusinessi	moustry
~ 1	be filed within 72 ho ital Hygiene. id other than "natui event, the Modical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ultry				Poult	<b>F</b> \'	
	filed with I Hygiene other than	ပိ	17. Father's Name (First, Middle, Last)		100	arer y	WOI KE	18. Mother's Nam	e (First Middle			
and and	ntal l	Be						_		Majoeii Suni	ame)	
Mattie	should be nd Mental r marked c	은	Ezekiel Hudson					lda Jar				
Maryland	d 2 should th and Mer 7 is marke traumatic	1	19a. Informant's Name/Relationship (					nd Number or Rui				
Th	1 a a a	11 3	Robert Niblett (n		1100	3 Gra	ys Co	orner Rd	. #47.	Berlin,	Md.	21811
V LL LA	ges 1 t of Hi if iter		20a. Method of Disposition  1X Burial 2 Cremation 3		20b. Place of Di	isposition (N crematory or	ame of		Date	20c. Locatio	n - City or 1	Town, State
S E	Pagent int: i		'4 □Donation 5 □Other (Specifi		Evergr	een C	emete	ry	04	Berlir	n, Md	i.
3 ==	permit. Departr Importa any inju		21. Signature of Fineral Service Licen	ISBB		22. Name	and Addres	s of Facility The	e Burba			
E C	Depa Impo any ii		K/Aug/	Sinkel				St., Be				Tione
`	* * *		23a. Part Entry Useas or com	plications that caused the	e death. Do not						-	Approximate
4			shock, or near tallure. A list only	one caus con each line.				,, 000., 00 00. 0.00	or roopmatory a			Interval Between Onset and Death
3	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Yone	mon	1a						week
BORDOULT	/Medical Examiner		resulting in seattly	Doe to (or as a c	onsequence of):							
00	Examinici		Sequentially list conditions.	b								
8	ד ס	nei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):							
	anth certiticate be executed attending physicien and for use as the burial-transit	Examiner	that inflated events	C							1	
60 60	en a en a rial-l		resulting in death) Last	Due to (or as a c	onsequence of):							
	te be ysici	cal	•	d								
Box 68	g ph	ed										
×	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of						23d. I	Date of deliv	verv
m	death a atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim		3 ☐Ectopic 5 ☐ Other (s					Month	Day Year
o,	that the de ed by the detached	ıys	9 Unknown	9□ Unknown			. ,,					
Division of Vital Records, P.O.	that the ed by detac	Completed by Physician/Medi	Part II. Other significant conditions of	ontributing to death but r	not resulting in th	e underlying	cause give	n in Part I.	23e. Did to	obacco use co	ontribute to	the cause of death?
S	sign d be	d b	-Congestive	heat	fail	418	•		101	res 2 🗓 No	3 □ Pro	bably 4 Unknown
Ö	w requir been s should	ete	0 12 00 0	100,1101	1011				-			
9	law last	du	atrial to	SILICET	100				24a. Was autop	sy	prior to co	topsy findings available ompletion of cause of
<u> </u>	The Late ha	ő							perfo 1 ☐ Yes	rmed? 2□Mo	death?	2 KNO
i e	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?					26. Place of Deat				= = =
2	Physician: this certific al director,	To	1 Yes 2 No	Hospital: 1 Impatient	2 ER/Outpa	itieni 3 🗆 🖸	Othe	r. 4 Nursing Ho	me 5 Resid	dence 6 □C	Other (Spec	cify)
0	tending Ph leath. tor: Atter th the funeral	ë	27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b. Tim		28c. Injury Work		28d. Describe I			
<u>.</u>	nding ith. : Atter e funer	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ AccidenI investigation		oar) Inju	M		es 2 No				
<u>.</u>	Attendi r death. octor: A	100	3 Suicide 6 Could not be determined	286. Place of injury	- At home, farm	, street, facio	ry, office		28f. Location (S	Street and Nu	mber or Rui	ral Route Number,
á	afte Dire	ert	4 Homicide	building, etc. (	Specity)				City or Tox	vn, State)		
	To the Hosp tal or Attsnding Physician: The law requires that the death certiticate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Ph	ysician: To the best of n	ny knowledne d	eath occurre	d at the time	e, date and place	and due to the	rause(s) and	manner ac	stated
	24 h Fur	Medical	(Check only 2 Medical Exam	niner: On the basis of ex and manner stated	(amination and/o	r investigatio	n, in my op	inion, death occur	red at the time,	date and place	e, and due	to the cause(s)
	thin 2 the the the the the the	Me	29b. Signature and title of certifier	and munitor states		2	9c. License	number		29d. Date sign	ned (Month	Day Yearl
	To To	1	bild it	Him	110	-	A . A	10000	-	Ci /	a a a	,, , , , , , , ,
			Musury	Suyger	1,40		0-10	00414	7	7-6-	04	
کے	7 1		30. N me and address of person who	completed datuse of deat	th (Ifem 23a) (Ty	pe, Print)	12-	900 200	100	(6)		3 8 5
	1 0		MITTING WHIT	TIV, WO	120	10	TSIA	- 11611	WHY!	The win	THE -	- SUAVUD, DE
	Sta		31. Date filed (Month, Day, Year)	32. Degistrar's	Signature	1.00	,					14944
	Regist	rar	SEP 1 8 2	1111/1 1 100000	. 17.	CHIEFEL.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Alfreida Ethel Prochazka September /Medical 2004 2:34 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🙀 F Director 577-<u>16-6311</u> 85 June 8, 1919 Wash. D.C. Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28a-f show other traumatic awant, the Medical Exemples must be notified at 1 ☐ Yes 2 → No Director West River Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With Items 23a 730 Shady Oaks Road Completed by Funeral 20778 death USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. int: If Item 27 is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ₩idowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) 10 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Alfred August Emil Jahn Olive Esther Litchfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 730 Shady Caks Rd., West River, MD Gary R. Prochazka, son 20778 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 09-04-2004 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cay s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on/ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** neumo horax resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760. attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?

1 □ Yes 2 □ No
9 □ Unknown for Month Day Year 5 Other (specify) be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 nknown Be Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? death? 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check on one examiner? 1 ☐ Yes 27 No Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide filled Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) To the I 29c. License number 29b. Signature and title-of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of perso, o completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registr Signature

Certificate of Death

Roberson

2. Date of Death

4c. County of Deeth

1929 Arkansas

14. Race - American Indian, Black, White, etc.

Specify: white

Federal Bureau of

Taneytown, MD 21787

23d. Date of delivery

Month

Day

3 ☐ Probably 4 XUnknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

Year

Approximate Interval Between Onset and Death

16b. Kind of Business/Industry

Investigation

N/A

9:16 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

Jesse

Lay

32. Registra s Signature SEP 1 7 2004 > **ORIGINAL** 

201 KMT

State

31. Date filed (Month, Day, Year)

1 - For State Registrar

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

		1	For State Registrar	State	of Maryla		artment of H		nd Me	_	giene Reg. No. ()	04	29621	
	Physicia		1. Decedent's Name (First, Middle	, Last)					1	<ol><li>Date of De Month</li></ol>	ath Day	Year,	3. Time of Deat	
	/Medic	al	Juanita Mae Rep	hann						8 -	18-	04	5:5/1	₽M
	Examin	er '	4a. Facility Name (If not institution			~ / /	4b. City, Town, or CVM 13			)		nty of Deeth	NV	
			SACRED HEA	6. Sex	0 SP / T	rs. last birthday)		If Under 2		8. Date of Bir	th	9. Birtho	lace (State or For	eign
	Funeral Director		216-22-5623	1 □ M 2 🔀 F	78	Yrs.	Months Days	Hours	Min.	(Month, Da 20-Nov-	y, Year)	Mary	itry)	- 3
-	ם	l ⊢	Usual Residence of Decedent							201101	1720			
	srylar show	_	10a. State 10b. County		10c.	City, Town or Lo	ocation					1	0d. Inside City Lin 1    Yes 2 □	
	8a-1	Directo		gany	Fro	stburg	404 7:- C-d-				10a Citizan	of lathon Cour		
	be filed within 72 hours after death with the Maryland Hygiene. I de Hygiene. I want to maitied a wealt, the Madical Examinat must be maitied at	Dir	10e. Street and Number 206 M	Maple Place	€		10f. Zip Code				10g. Citizen	or witat Cour	nty t	
	eath	Funerai	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	21532- Was Decedent of Hi	ispanic Origi	in? (Spec		U.S.A.	Race - Americ	an Indian,	
0	r Iten	Fun	1 ☐ Never Married 2 ☐ Marr	ied Armed F	orces? 2 XNo		If Yes, specify Cuba	in, Mexican,	Puerto R	tican, etc.)	E	Black, White,	etc.	
ğ	al', o	ρ	3 Widowed 4 ☐ Divorced	If Yes, G Year or	ive Dates:		1 ☐ Yes 2 No	Specify:			Spe	white		
21215-0036	72 ho	Completed	15. Deceden (Specify only highe	t's Education st grade completed	)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most	of workin	g	16b. Kind of	f Business/In	dustry	
21	ithin nen "	mpi	Elementary/Secondary (0-12)	College	(1-4or 5+)			1)						
2	led w tygier her ti	S	17. Father's Name (First, Middle,	(201)		nurse	s assistant	18 Mother	's Name	(First Middle	nursing h			
Maryland	0 = 5	m		Lasij							, marouri ouri	idinoj		
Ë	S should be filed within and Mental Hygiene. Is markad other than aumatic event, the Mematic event ev	2	Allen L. Dennison  19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ing Address (Street a	Nellie and Number			er. City or Tox	wn. State. Zic	Code)	
<u>S</u>	trau		Kathy Sue Richard		ghter		rant Street		Frostb			ryland	21532-	
ē,	Hea Hea Item		20a. Method of Disposition		200	. Place of Disp	osition (Name of matory or other place			ate		on - City or To		
Ë	Page: ent o nt: If		Burial 2 Cremation 4 Donation 5 Other (5			stburg Mer			20-Au	g-2004	Frostburg	g M	aryland	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic e once.		21. Signature of Funeral Service	Licensee	1	2	2. Name and Addres	ss of Facility	,					
m	Depa Impo any i		Jolen To	Alur	4		urst Funeral I					, MD 2	1532	
	Physician /Medical Examiner	ner	23a. Page. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due	each line.	Right sequence of):	Cereba. Persele	ing, such as o	fac	Tran	rrest,		Approximate Interval Between Onset and Death	
c 68760,	death certificate be executed e attending physician and id for use as the burial-transit	Medicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	d	o (or as a cons									
P.O. Box	that the death certifit ed by the attending I detached for use as	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	utcome of pre birth 2 F gnant at time on nown	etal death 3	□Ectopic pregnancy □ Other (specify)	,				Date of deliver Month	ery Day Year	
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions	ens contributing to	death but not	plvic	underlying cause giv	Vasce	ly	23e. Did 1	1		he cause of death pably 4 □Unkn	
I Records,	The law ate has b page 2 s	Completed	Accidents							24a. Was auto perfo 1 🗆 Yes		prior to co death?	ppsy findings avail impletion of cause 2 No	able of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medica examiner?		a a		0.15		of Death	(Check only	one)			
of	8 v 7	2	1 Yes 2 No 27. Magner of Death	Hospital: 1	e of Injury	28b. Time		4 🗀 1901			how injury oc		<b>(y)</b>	
n (	ding Phy. h. After thi funeral	ion:	1 Natural 5 ☐ Pendi	/8.4	onth, Day Year		Wor	rk? Yes 2⊡N		.od. Describe	now injury oc	cuited		
Division	Attending r death.	licat	2 Accident Invest 3 Suicide 6 Could deter	not be	ce of Injury - A	At home, farm, s	treet, factory, office			8f. Location (	Street and Nu	umber or Run	al Route Number,	
<u>S</u>	after Dire	Certificati	4 Homicide		lding, etc. (Sp					City or To	wn, State)			
	To the Hospital or Attention 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		Exeminer: On the			ith occurred at the tir nvestigation, in my o							
	To the within 2 To the complet	₹	29b. Signature and title of certific	1 / . 1	1		29c. Licens	se number			29d. Date sig	gned (Month,	Dey, Year)	-
)	$\Rightarrow$		N-4	+-Kanjili	(2)		101	431	8		Hug	ist	1414 70	04
	MAS		30. Name and address of person	AN mo	use of death (	Item 23a) (Type	Print) Read (	J. com	ber	land.	mal.	21.	1912 20	
	St Regist	ate trar	31. Date filed (Month, Day, Year AUG 2	0 2004	Registrar's Si	ignature	& span	les						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. U U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 4, **Physician** AMELIA CELESTE THOMAS ROLLEY 2004 7:00 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NEW LIFE ASSISTED LIVING WALDORF CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days (Month, Day, Year)
SEPTEMBER 25,1916 MARYLAND Hours 1 □ M 2 🗓 F Yrs. 577-28-4109 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits s 23a or 28a-f show 1 Yes 2 No Directo WALDORF MARYLAND CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 110 JEFFERSON ROAD 20602 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ♠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify 3 Widowed 4 □ Divorced BLACK "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 2 YEARS EXECUTIVE ASSISTANT FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental ant: If item 27 is marked o MARY ELIZA HARRIS THOMAS HENRY CLAY THOMAS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 la MARY BURWELL / NIECE 1015 18TH STREET, N.E.#2, WASHINGTON, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or METROPOLITAN CHURCH CEM. SEPT. 10, 2004 INDIAN HEAD, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicenses THORNION FUNERAL HOME, P.A. any LYDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death ralmonaru Drosis **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): the burial Division of Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t Part II. Quer significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 ☐ Yes 2 ☐ No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred or Attending 5 Pending Injury 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide \*\*To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check or

To the Hospital

State Registrar

SEP 0 8 2004

30. Name and address of

ture and title of

rtifie

29d. Date signed (Month, Day, Year)

04

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Adgust 31 **Physician** Germaine Marquerite Rothka 20094 4:30 RM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 325 Dew Drop Lane Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. DEC 24 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□ M 25 F Year 928 Germany 75 Director 207 34 9614 Usual Residence of Decedent with the Maryland 10a. State 10b. County
Maryland Calvert 10d. Inside City Limits 10c. City, Town or Location
Prince Frederick 27 Is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 325 Dew Drop Lane 20678 United States death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Ita 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antoine Wagener Christine Diederich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lori Kelly - daughter 325 Dew Drop Lane Prince Frederick MD 20678 other 20b. Place of Disposition (Name of cemetery, crematory or other place Sept 1 2004 Alexandria Virginia Metropolitan Funeral Service 20a. Method of Disposition 1 Burial 2 Ferenation 3 Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee SKauso 4405 Broomes Is. rd. Port Republic MD 2067 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician disease or condition resulting in death) Varian /Medical Tue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 o 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t autopsy performe 2.Z.No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ 🛪 o 10 After this c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier D59061 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 10 Prince Frederick 1-to50 tok Ste 212 10 s Signature Registra State Registrar

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of M	faryland / Der Co			Mental Hygi	-	)4 29627
Physic	an	Decedent's Name (First, Mide					2. Date of Death Month	Day	3. Time of Death
/Medi		ANDREW	RUDOLF	SCHROC	K, SR.		Aug	27	04 18 28 M
Exami		4a. Fecility Name (If not instituti	on, give street and number	7		or Location of Death	)	4c. County	
		PENINGUIA REGI	ONAL MEGICA	CONTU		CISBURY			(CoMICO
Funeral Director		5. Social Security Number 222-12-8001	6. Sex 7. A	nge (In yrs. last birthda 78 Yrs.	Months Days		8. Date of Birth (Month, Day, JULY 02,	Year)	Birthplace (State or Foreign Country)
g		Usual Residence of Decedent					DOLL UZ,	1920	ALABAMA
arylar show	_	10a. State 10b. Count	У	10c. City, Town or	Location				10d. Inside City Limits
he Ma	ecto	DELAWARE Si	USSEX	GEORG					1 □ Yes 2 No
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28e-1 show other traumetic event, the Medical Examination to the an	Funeral Director	9 SNOW RO	ΔD		10f. Zip Code	<i>l.</i> 7		)g. Citizen of V <b>JNITED</b>	
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or ite	표	1 ☐ Never Married 2 X Ma	Armed Forces	i? ]No	Was Decedent of If Yes, specify Cub		Rican, etc.)		ck, White, etc.
ours a	d by	3 Widowed 4 Divorce	If Yes, Give Year or Dates	1944-46	1 ☐ Yes 2 🛣 No	Specify:		Specify	WHITE
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within ener	mp	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retire ELECTRICIA			CEL E	TIME OVER
Hygie N. Hygie	င်	17. Father's Name (First, Middle	. Last)		PPECIKICI7		e (First, Middle, M		EMPLOYED
ylan	To Be	RUDOLF	SCHROCK					CHROCK	5,
Maryland 21215-UU36 Id 2 should be filed within 72 hours alt th and Mantal Hyglene. It is marked other then "natural", or traumetic event, the Medical Event	-	19a. Informant's Name/Relation	nship (Type, Print)	19b. Ma	ling Address (Street	and Number or Rui			State, Zip Code)
and 2 and 2 salth a n 27 is		WILLIAM SCI	HROCK (SO	N) 903	CHURCH ST	r. UPLA	ND, PA 1	9015	
A 60		20a. Method of Disposition  1  Burial 2  Cremation	3 Personal from State	20b. Place of Dis	ematory or other pla	ce)		0c. Location -	City or Town, State
Pages ment of land: if its ury or o		'4 □Donation 5 □ Other		CREMATOR	Y OF DELM	ARVA AUG.	31,2004	DELMAR	R, DELAWARE
Dallimore, permit. Pages 1 a Department of Her Important: if itam any injury or otha		21. Signature of Funeral Service	Licensee	1	22. Name and Addre VATSON FUN VILLSBORO	NERAL HOM	E, INC.		
		23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications hat cause st only one cause on each	ed the death. Do not e line.	nter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Brain	Deat	h			Onset and Death
/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):		i.e. l			2 1 1100
LAdiminei		Sequentially list conditions,	b	assive Su	popular!	News ter	27		
ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequence of).					
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
The law requires that the death certificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	cal E		d						
ifficate g phys			d.						
eath certific attending p	M/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregnance			23d. Date	e of delivery
deat deatt	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)	у		Mor	nth Day Year
at the de	Phy	9 Unknown							
res that	by	Part II. Other significant condit	tions contributing to death	but not resulting in the	underlying cause giv	en in Part I.			ibute to the cause of death?
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nacolus, he taw requires t e has been signe age 2 should be o	Completed		3/ 72				24a. Was an autopsy	q	Vere autopsy findings available rior to completion of cause of eath?
			868				perform 1 □ Yes 2	No 1	Yes 2 No
S & S &	o Be	25. Was case referred to medic examiner?  1 X Yes 2 □ No	11 21 1		ont 3 DOA Oth	100	h (Check only one,		
Py Granting	<del> </del>	27. Manner of Death	Hospital: 1 Inpat	ury 28b. Time	of 28c. Injur	ry at	me 5 Residen		
Attending of r death, sector: After by the funer	atloi	1 □ Natural 5 □ Pend 2 □ Accident inves	tionston with	ay Year) Injury	P M 1□	rk? Yes 2 No	Falla	t hore	
Lor Attending after death, Director: Afte	tifle	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be 28e. lace Ir	njury - At home, farm, s	treet, factory, office			et and Numbe	er or Rural Route Number,
tal or A safter al Dire	Certification;		To.	Crive			7 Snow Kird	CHONE	bun DE 1954)
To the Hospital or a within 24 hours after To tha Funeral Dire completely filled in b		(Check only 2 Medica	ing Physician: To the bes I Examiner: On the basis	t of my knowledge, dea	ith occurred at the tir	me, date and place,	and due to the cau	ise(s) and fran	nner as stated.
To the H within 24 To tha F complete	Medical	one)	and manher s	tated.		j			```
Viil Co	<	29b. Signature and title of certific	er L	MAK	29c. Licens	/	ME 290	J. Date signed	(Month, Day, Year)
		1 julia	N. J.	Mens	31 "	/1)-	7 / 7	144	
T 10+1		30. Name any address of perso	n who completed cause of	death (Item 23a) (Type	(Print)	501:01	.1 M	) 010	0/
Sta	te	31. Date filed (Month, Day, Yea		irai s Signature	011 31.	JUISW.	14 1111	~180	//
Registi	A	/ SEP	0 2 2004	earn . H	booth				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** September Edith Mae Sodero 2004 2:25 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 245 Owings Hill Court Owings
If Under 1 Year | If Under 24 Hrs. Calvert 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours Min 1 ☐ M 2 😾 F Yrs. Director 9, 1930 74 579-44-6412 Virginia Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show the Medical Examiner must be nutified at 1 ☐ Yes 2 No Director Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23e death y 245 Owings Hill Court 20736 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or item any injury or other treumatic event, it e Medical Examiner 9066. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore E. Geisler 2 Mabel Pearl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 245 Owings Hill Court, Owings, MD Date 20c. Location Nick Sodero, husband 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Washington National 09-04-2004 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only sea cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): Examiner Mesothelioma year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate be executed burial-transit nding physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant the atten 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Dav 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2□ No 1 Tes 2X No 1 TYRS Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 V Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 45435 9 - 3 - 0430. Name and address of person who completed cause of death (Item 23a) (Type, Print) (N 2419 Solomons Is. Rd., Huntingtown, MD 20639
32. Register's Signature Varkey Mathew, M.D., 31. Date filed (Month, Day State Registrar

			For State	State of Maryla		artment of F		d Mental Hy	0.0.0.1	00100
			Registrar  1. Decedent's Name (First, Middle, Last,	1		Timoato or	Death	2. Date of De	Reg. No.	3. Time of Death
	Physici		Russell Jacks		.Jr.			Month	Day Year	м.
	/Medic Examir		4a. Facility Name (If not institution, give		, 01.	4b. City, Town, o	r Location of De	Augus	± 31, 2004 4c. County of Dec	1445 p
	LAdiiii	ICI	Calvert Memorial	Hospital		Prince	Freder	rick	Calve	
	Funeral	27	5. Social Security Number 6. Sec.		rs. last birthday)	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Bi	rth 9 Bi	rthplace (State or Foreign
	Director		219-46-9648	M 2□F 57	Yrs.	World Days	Tiodis in	Dec.	14, 1946 Wa	shington, DC
	pu 🔭		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
	shor	5	MD Calver		•	ingtown				1 ☐ Yes 2 No
	28a-1	Director	10e. Street and Number		IIuII (.)	10f. Zip Code			10g. Citizen of What C	Country?
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event, it s Medical Exercili set is use for redifficed at		1461 Bidwell Lar	ne		206	39		USA	ountry:
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in		Was Decedent of H	fispanic Origin?	(Specify Yes or No		erican Indian,
(0	ritar	Fun	1 Never Married 2 Married	Armed Forces? 1XXYes 2 ☐ No		If Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)	Black, Wh	
Ö	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
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7	ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d) _	, o, m, r, g		
7	filed withi Hygiene. othar than	S			Sea	Food Man			Grocery	- Retail
E I	tal H	Be	17. Father's Name (First, Middle, Last) Russell Jackson	Cwatnam C	7			•	, Maiden Sumame)	
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Maryland	8 8 B	8.3	19a. Informant's Name/Relationship (T) Susan Swetnam (W			Bidwell			per, City or Town, State,	
	Health Health tam 27 other tr		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	. Place of Dispo	osition (Name of		untingtow	vn, MD 2063 20c. Location - City o	
Baltimore,	Pages nent of P ant: If itu		1 Burial 2 Cremation 3 F	Removal from State	cemetery, crei	matory or other pla	,	ept <sup>ate</sup> 3		
薑	permit. Pag Department Importent: I any injury o		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		ee Cren			2004	Clinton,	
Ba	permit. Pages 1 an Department of Heal Importent: If itam 2 any injury or othar once.		Gary J. Ge		01	25 South	own Mow	ee runera yland Blv	al Home Calv	
	_		23a. Part1. Enter the disease, or compl							Approximate
ĸ.			shock, or heart failure. List only o	ne cause on each line.						Interval Between Onset and Death
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9	ng ph as th	Jed	IF FEMALE:							!
Sox	leath certific attending p	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F		Ectopic pregnanc	,		23d. Date of de	livery Day Year
O.	the at	slcl	in the past 12 months?	4☐ Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Feat
P.0	that the ded by the	Phy	9 Unknown	and the state of a state back as a state of	lai i ab		on in Book I	22a Did	tabassa usa santsibuta (	a the serves of death?
Ś	es ign	by	Part II. Other significant conditions co	ntributing to death but not i	esuiting in the u	inderlying cause giv	ren in Part I.		tobacco use contribute t Yes 2 □ No 3 □ P	robably 4 Chknown
Record	w require been s	Completed						- ''	705 2 NO 3 F	robably 4 Delikitowit
ec	has by	ple						24a. Was	psy prior to	utopsy findings available completion of cause of
<u> </u>	Th ate pag	Con						y Period	ormed? death? 2 □ No 1 Ø Ye	s 2 No
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of \	Physician: this certific ral director,	은	IX tes 2 No		☐ ER/Outpatier		4 🔲 Nursing		idence 6 Other (Spe	ecify)
		On:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year,	28b. Time o Injury	Wo	k?	28d. Describe	how injury occurred	
Division	r Attending er death. ractor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	DO - Disea of Injury A	1 h 1		Yes 2 □ No	206 Leasting (	(Careet and Number of C	hard Courts At an hard
Ξ	I or Attencater death	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t nome, tarm, sti ecify)	reet, factory, office		City or To	(Street and Number or R wn, State)	urai Houre Number,
_			29a. Certifier 1 ☐ Certifying Phy	sision. To the boot of much	raculadas dast	h assumed at the ti	mo data and pla	and due to the	acusa(a) and manner a	o state d
	Hos 24 ho Fun Fun	Medical		sicien: To the best of my length of the basis of exam and manner stated.						
	To the Hospite within 24 hours To the Funaral completely filled	Me	29b. Signature and title of certifier	and marrier stated.		29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
	⊢ ≯ ⊢ ŏ		1 1 0 0	1.00	110	OCME			September 2	2. 2004
			30. Name and address of person who co	ompleted cause of death	tem 23a) (Type,	Print\				
10	2+1		Tasha Zan	1	. D	111 P	enn Str	eet, Balt	imore, Mary	yland 21201
		ate	31. Date filed (Month, Day, Year)	32. Registras Sig						
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			1 - For State Registrar	State of Mary		artment of F rtificate of			ene 1. No.2004 2963	3 ()
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	Examir Funeral	ner	4a. Facility Name (If not institution, give s  UMMS  5. Social Security Number 6. Sex	7. Age (Ir	n yrs. last birthday)	Balte If Under 1 Year	or Location of Dea	S. 8. Date of Birth	4c. County of Deeth  9. Birthplace (State or Fo	oreign
o 2	Director		217-84-8972 Usual Residence of Decedent		43 Yrs.	Months Days	Hours Min	May 22,	ear) Country)	_
	e Marylan 8a-f show Ullied al	Director	MD 10a. State 10b. County Calvert		c. City, Town or Lo Lusby				10d. Inside City L	
36	hin 72 hours atter death with the Maryland B. In "natural", or Items 23a or 28a-1 show Medical Examiner must be notified at	by Funeral Dire	10e. Street and Number  12451 Algonquin Tr  11. Marital Status  1 Never Married And Married  3 Widowed 4 Divorced	ail  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 □ No If Yes, Give X Year or Dates:			657 dispanic Origin? (/ an, Mexican, Puel Specity:	Specify Yes or No- rto Rican, etc.)	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: white	
Maryland 21215-0036	돌	Completed I	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give life, L	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking 16	own home	
land 2	ges 1 and 2 should be filed wit t of Health and Mental Hygiens If Item 27 is marked other thy or other traumatic event, Ite	To Be C	12 17. Father's Name (First, Middle, Last) Theodore L. Ch	ura	TION	EHOVET	18. Mother's Na Marga	me (First, Middle, Ma		
	and 2 should to ealth and Menture 27 is marked har traumatic e		19a. Informant's Name/Relationship (Type Frederick W. Slack	, husband	12451	Algonqu		, Lusby, M	City or Town, State, Zip Code)  ID 20657	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		20a. Method of Disposition  1 ☐ Burial 2. 及Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Spedify)	emoval from State	etropolit	natory or other plac tan Crema	tory 09		c. Location - City or Town, State	
Bal	Depar Impor		21. Signature of Funeral Service Lidense	ellau	R		neral Ho		Owings, MD 20736	
2	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Fmal disease or condition resulting in death)	Due to (or as a co	TRSTAT	TC LL			Approximate Interval Betwee Onset and Deat	
8760,	death certificate be executed e attending physician and der use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that indiated events resulting in death) Last	Due to (or as a co						
.O. Box 6	death certifi e attending j d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ② No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,	•	23d. Date of delivery Month Day Year	r
<u>a</u>	res tha igned be del	þ	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to the cause of death	
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Division	or Attenctor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)		Yes 2 □ No	28f. Location (Stree City or Town, S	nt and Number or Rural Route Number, State)	
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	Tot. withi Totl	W	29b. Signature and title of certifier	Z/		29c. Licens			Date signed (Month, Day, Year)	
<u>;</u>	5		BO Galtes	mpleted cause of death	(Item 23a) (Type, I	Print)	ST E	SOUTHS,	2170/	
	Sta Regist	- 0	31. Date filed (Month, Day, Year)	32. Registrates	Signature &	Bonko				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** August 27, 2004 6:40 p Elmer Saunders /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Nov. 6, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 78 Yrs. 137-20-5939 Director New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Calvert St. Leonard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5724 Oakcrest Drive 20685 U.S.A. or Itama 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 and 2 should be filled within 72 hours after. Health and Mental Hygiene. em 27 le marked other than "netural", or Ita 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 accountant accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Saunders Beatrice Ball ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health a Importent: If Item 27 le any injury or other trat 5724 Oakcrest Dr., St. Leonard, MD Maxine V. Saunders, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation \_ 5 ☐ Other (Specify) Charles Memorial Gardens08/31/04 Leonardtorn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Port Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Prysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Hospitel or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 Z No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel of within 24 hours at To the Funaral D completely filled in 29a. Certifier Mccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) certifie 29b. Signature and title of

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

State

Registrar

30. Name and address of serson who co

31. Date filed (Month.

DHMH 17 Rev 1/2001

(ed cause of death (Item 23a) (Type, Print)

s Signature

32. Registra

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		1 - State Registrar		State of W	iai ylailu		tificate of l		-	Reg. No.	004	29632	
Physicia	an	1. Decedent's Name (F	First, Middle, Las	Edith I	) Wilso	on	*		2. Date of De. Month	Day		3. Time of Death	
/Medic Examin	al	4a. Facility Name (If no	ot institution, give			OIT	4b. City, Town, or	Location of Deat	AUGUST	18,	2004 County of Death	11:07 <sup>M</sup>	
LAdiiiii		Memorial	Hospita				CUMBER	LAND		AL	LEGANY		
Funeral Director		5. Social Security Num 216-30-16	681 1	ex 7. A □ M 2 ☐ F	ge (In yrs. las 72	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year) [8, 19]	32 9. Birth Mar	place (State or Foreign nto) 'Yland	
land bw		Usual Residence of De 10a. State 10	ocedent Ob. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
Mary a-f sho	tor	Maryland	All	egany		Cumberland					1√2 Yes 2□N		
or 28	Direc	10e. Street and Number					10f. Zip Code	04 = 00		10g. Citizen of What Country?			
sath w	erall	44 Marian Status	223 1	Fulton St.	Ever in II S	13 1	Vas Decedent of H	21502	Specify Ves or No	. 11	U 14. Race - Ameri	SA can Indian	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other treumetic event. Ite Madical Examiner and the mailfied at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 [	_	Armed Forces  1 Yes 27  If Yes, Give Year or Dates:	?  No		Vas Decedent of H f Yes, specify Cuba I□Yes 257 No	Specify:	to Rican, etc.)	}	Black, White		
72 hou	eted	15	5. Decedent's Ed only highest gra	ducation			lent's Usual Occupa		rkina	16b. Kir	nd of Business/Ir	ndustry	
ne. hen "	Completed	Elementary/Seconda		College (1-4or	5+)	life. L	DO NOT use retired	sekeeper	-		Private	homes	
filed v Hygie other t		17. Father's Name (Fire	rst, Middle, Last)				1100		me (First, Middle,	Maiden		Tiorries	
uld be Mental irked c	To Be		Josep	h Arthur V	Vilson		Mary Catherine (Beeman					nan)	
nd 2 sho alth and N 27 Is ma		19a. Informant's Name		<sub>Турв, Print)</sub> d/daughte	er	19b. Mailin	ng Address (Street and Number or Rural Route Number, C 7 1/2 Parkside Blvd., I						
of Head	-	20a. Method of Dispos		Removal from State	cen	netery, cren	sition (Name of natory or other place	e) 0	Date / 04		cation - City or T		
t. Pag rtment rtant:		° 4 ☐ Donation	Other (Specif		Rose		Cemetery		/21/04		lumberla		
Depariment Department of the police once		21. Signature of Flune	INT.	#1			. Name and Addres				eral Hon		
A.		23a. Part1. Enter the shock, or heart fa	disease, or com	p ca ions that cause	d the death.	Do not ent	ar the mode of dyin	g, such as cardia	or respiratory a	mbci rrest,	rland, M	Approximate Interval Between	
Physician	Į II	Immediate Cause (Findisease or condition		1		y Dia	sease-Acu	te and C	hronic		,	Onset and Death	
/Medical Examiner		resulting in death)		Due to (or a	Ob a tra	nce of):	Dulmona	ry Disea	SA-OVOVA	n da		75 years	
	ler	Sequentially list condit if any, leading to imme	ediate 📕		s a conseque		: I dimona	Ly Disca	orgy c		pendent	rsyears	
tificate be executed ig physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):											
rificate be executed ng physician and as the burial-transit		resulting in death) Las	ST.	Due to (or a	as a consequence of):								
icate l	Aedical		•	d	_								
ath cer attendir for use	Physician/Mo	IF FEMALE:  23b. Was decedent pring the past 12 mo 1 ☐ Yes 2 ☐ N  9 ☐ Unknown	onths?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3	Ectopic pregnancy Other (specify)			2	3d. Date of deliv Month	ery Day Year	
w requires that the de been signed by the should be detached									23e. Did to	obacco us	se contribute to t	he cause of death?	
equires en sign	ed by	Diabetes Me	ellitus-	- Type 2					101	Yes 2	QNo 3□Pro	babły 4 Unknown	
sicien: The law re certificate has be irector, page 2 sho	Completed								24a. Was autop perfo 1 \( \text{Yes} \)	rmed?	24b. Were auto prior to co death? 1 \( \subseteq Yes	opsy findings available impletion of cause of	
Physicien: r this certifica ral director, p	Be C	25. Was case referred examiner?	to medical	Honeital:			Out		ath (Check only o	ne)			
Physi r this c ral dir	. To	1 ☐ Yes 2 No 27. Manner of Death	)	Hospital: 1 ☐ Inpat		VOutpatien  8b. Time of		4   Nursing r	dome 5 ☐ Resident 128d. Describe I			fy)	
nding I ith. :: After e funer	atlon	8.4	5 Pending investigation	28a. Date of In (Month, D	ay Year)	Injury	Worl	k? Yes 2 □No		,_,			
el or Attences after death	Certification:	3 Suicide 4 Homicide  3 Suicide 4 Homicide  3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number of City or Town, State)									al Route Number,		
To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier 1 (Check only one)		ysician: To the bes hiner: On the basis and manner s	of examinatio								
To the within 52 To the comp	Me	29b. Signature and titl	le ol certifier	Mam	4		29c. Licenso D160				signed (Month,		
70. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terry Williams M.D. 500 Memorial Avenue Cumberland, Maryland 21502													
,,,,=0		Terry Will	iams M.	J. 500 Mer	norial	Avenu	ie cumber	Tanu, Ma	ryrand 2	.1302			

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
AUG 2 3 2004

32 Registrar's Signature

			For State Registrar	State of Ma	ryland / Depa <i>Cel</i>		of Healt of Dea			giene Reg. No.	000	29633
	Physicia /Medic	al	Decedent's Name (First, Middle, Last     William Fulton     4a. Facility Name (If not institution, give	Wheele	r	4b. City. 7	Town, or Locat	tion of Death	2. Date of De Month Sept.	5, Day	2004 County of Death	3. Time of Death 7:05 p <sup>M</sup>
-	Examin Funeral	ier	8285 Warren Dr. 5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)		omfre	t nder 24 Hrs.	8. Date of Bir	th	Charle 9. Birth	PS  Applace (State or Foreign untry)
	Director	or	220 – 34 – 8526  Usuel Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo				Oct.	¥,193	L4   Mar	yland  10d. Inside City Limits  1 □ Yes 2X No
G K I K I 3-0000 filed within 72 hours after death with the Marylend	s 23a or 28a-f show	Funeral Director	MD   Charles  10e. Street and Number  8285 Warren Dri  11. Marital Status		Pomfret	10f. Zip (	675	Origin? (St		USA	en of What Cou	
hours after d	"natural", or Items 23a	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2			pecify Yes or No Rican, etc.)	5	Black, White Specify:	eck
L L L L L L L L L L L L L L L L L L L	Mental Hygiene. arked othar than "na atic event, the Mental	Completed	(Specify only highest grade  Elementary/Secondary (0-12)  6th grade  17. Father's Name (First, Middle, Last)		(Give	kind of word DO NOT usi	k done during e retired)			Char	les Co	o. Board o
should be	and Mental Hygiene. Is marked othar than reumatic event, the M.	To Be	James A. Wheele			400-NV	Man (Street and Nu	cy Es	telle ral Route Numb	Whee	1er Town, State, Z	ip Code)
Definitions, IN	Department of Health and Mental Hygiene. Important: If Items 23a or 28a-f show any injury or other treumatic event, I'te Medical Examiner must be notified at ones.	3	William A. Whee  20a. Method of Disposition  1 Aburial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signature of Funeral Sofvice License	Removal from State	20b. Place of Dispo cemetery, cre.	osition (Nammatory or other <b>A Tuis</b> 2. Name and	e of her place) d Address of F	09-1	ehart-	20c. Loc Po Echo	ation-City or To 1s Fur	
,	nysician Medical xaminer		23a. Part1. Enter the disease, or comp shook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused to the cause on each line.  a. Due to (or as a	the death. Do not en	ter the mode		h as cardiac	or respiratory a			Approximate Interval Between Onset and Death
The law requires that the death certificate be executed	physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):							
D. DOX of	ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death 3	⊒Ectopic pre ⊒ Other (spe		,		23	3d. Date of deli-	very Day Year
wrequires that	been signed by should be detac	by	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the u	inderlying ca	tuse given in P	Part I.	23e. Did t		/	the cause of death?
	s certificate hes b lirector, page 2 st	e Completed	25. Was case referred to medical				26. F	Place of Dea	24a. Was auto perfo 1  Yes	psy prmed? 2 No	24b. Were aut prior to death? 1 \sum Yes	copsy findings available ompletion of cause of
DIVISION OF VICE	within 24 hours after death.  To the Funerel Diractor: After this certificate hi completely filled in by the funeral director, page	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1-Patural 5 Pending investigation  3 Suicide 6 Could not be determined		Year) 28b. Time of Injury	of 28	Bc. Injury at Work?	Nursing H	28d. Describe	how injury Street and		ral Route Number,
the Hoenite	in 24 hours the Funerel	edicai	(Check only 2 Medical Examone)	ysician: To the best of iner: On the basis of and manner stat	examination and/or in	vestigation,	in my opinion,	death occu		date and p	place, and due	to the cause(s)
T	Twith	M	29b. Signature and title of certifier  30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	ī	License numl	694	9 BA11	9/	F D	y Jay, Tear)
1	000 Sta	ate		1100 HW	4 1 57				PLAT		40-	20646

WILLETT

GRACE

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Hilda Willett Grace SEPTEMBER 7 2004 8:45 a /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Y 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Yoar 919 Virginia 1□M 2X F Yrs. 579-07-4565 85 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Maryland St. Mary's Clements 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 24791 Horseshoe Road 20624 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2\text{\text{\$\exitt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\exitt{\$\texit{\$\text{\$\text{\$\exititit{\$\text{\$\text{\$\text{\$\text{\$\text{\$\tex{ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No δ Specify: Specify: 3 XWidowed 4 ☐ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Prince Georges Co. Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Food Service Worker Department of Health and Mental Hygis Important: If item 27 is marked other is any injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Arthur White Eagle Viola Frances Proctor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Gooding - Son 24791 Horseshoe Road, Clements, MD 20624 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Trinity Memorial Gdns 9-9-2004 Waldorf, MD 22. Name and Address of Facility Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604 21. Signature of Funeral Service Licensee M01391 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dertic Shock /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physiclan/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No for Month Year Day 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t I be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been signal Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0060773 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. MARYS HOSPITAL LEONARDTOWN MD DR MEHRDAD AKHLAGHI 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature

State

Registrar

SEP 0 8 2004

Registrar

31. Date filed (Month, Day, Year) SEP 2 0 2004

PUBIO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MO

32. Regiarar's Signature

Year

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of M		d / Depa		Health and	•	giene	egible.	20636
	Physic	ian	Decedent's Name (First, Middle, La	st)		001	incate of	Death	2. Date of D		J () 14	3. Time of Death
	/Medi	cal		KLIN ANDRE					Stoken	ber 16	2009	1313 am
	Exami	ner	4a. Fecility Name (If not institution, giv	e street and number)	Mas	as tol	Ab. City, Town,	or Location of Deat	Ly		unty of Deat	h
	Funeral		5. Social Security Number 6. S	Sex 7. Ac	e (In yrs. I	ast birthday)	If Under 1 Year			irth	/A	hplece (State or Foreign
	Director		238-46-9022	XXM 2□F	73	Yrs.	Months Days	Hours Min.	(Month, D MARCH	ay, Year)	_ Co	RTH CAROLINA
	and		Usuel Residence of Decedent  10a. State 10b. County		10c City	, Town or Loc	ation					
8	Maryl feho	į	MARYLAND N/A									10d. Inside City Limits 1 X Yes 2 No
3	death with the Maryland ms 23a or 28a-f ehow	Director	10e. Street and Number		J	BALTIM	10f. Zip Code			10a. Citizen	of What Co	
50	23a c	al D	4019 BONNER ROA	AD			212]	16		U.S.		<b>,</b>
3	after death with the Marylar or frams 23s or 28s-f show	une	11. Marital Status	12. Was Decedent Armed Forces?		S. 13. W		Hispanic Origin? (S van, Mexican, Puert	pecify Yes or N o Rican, etc.)	0- 14.	Race - Amei Black, White	
36	urs aft	by F	Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ Yes, Give Year or Dates:	No	1	☐ Yes 2 🛣 No			ĺ	ecity: BLA	
5-0036	72 hours after naturel', or Ita	Completed by Funeral	15. Decedent's Ec (Specify only highest gra	1000		16a. Decede	ent's Usual Occup	pation			of Business/I	
21	within 7 ene. than "r	npie	Elementary/Secondary (0-12)	College (1-4or 5	5+)	(Give k	ind of work done O NOT use retire	during most of wor d)	king			
22	filed w Hygier Sthar th		9th grade  17. Father's Name (First, Middle, Last)			MAC	HINIST				BETH S	STEEL
and	ld be f ental } ked of	To Be	NATHAN ANDREWS					18. Mother's Nan			name)	
ary /	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 le marked other than "naturel", or Items 23a or 28a-f ehov any injury or other traumatic event, Ita Medical Examinat must be notified at ance.	F	19a. Informant's Nama/Relationship (	Type, Print)		19b. Mailing	Address (Street	HENRIET			wn State 7	in Code)
` ≥	and 2 salth a n 27 ic		Doreen Andrews/Da	aughter				Ave., Ba				
	Pages 1 nent of He int: If Item		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	20b. Pl	ace of Disposi metery, crema	tion (Name of atory or other place	ce)	Date		on - City or T	
(M) Baltimore	t. Pag rtmen rtant: njury		*4 □ Donation 5 □ Other (Specify	()	MT	ZION C			17-04	LANDSI	DOWNE,	MARYLAND
Bal	Department of the population o		21. Signature of uneral Service Licen	S <del>80</del>		WI.	Name and Addre LLIAM C	ss of Facility BROWN COI	MMUNITY	FUNERA	AL HOM	IE P.A.
	-4 - 4		23a. Part1. Enter the disease, or comp	olications that caused	the death	12	06 W NOR	RTH AVENU	$\mathbf{E}$			Approximate
	Physician		Immediate Cause (Final disease or condition	one cause on each lin	sta	416	// /	n Car				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	Color	(00)				
	Lamine	_	Sequentially list conditions,	b. Doorte for one		0						
	nsit	Examiner	Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):						
Ć.	e be executed /sician and e burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):			_			
1760,	<u>w</u>	icai		d								
89	eath certificat attending phy for use as th	Med	IF FEMALE:									
Bo)	ath cert attendin for use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal	death 3 □E	ctopic pregnancy	•		1	Date of deliv	*
0	by the datached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5⊡ C	Other (specify)				MOUTH	Day Year
∠ Division of Vital Records, P.O. Box 68	Hospital or Attending Physician: The law requires that the death certifical 44 hours after death. Funeral Director: After this certificate has been signed by the attending phytely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Medi	Part II. Other significant conditions co	ontributing to death bu	ut not resul	ting in the und	erlying cause give	en in Part I.	23e. Did t	obacco use co	ontribute to t	the cause of death?
ords	w require been sig should b						-			Yes 2□No		$\sim$
900	law relas be	ompleted							24a. Was	an 24i	b. Were auto	ppsy findings available
<u>=</u>	: The lav	Con								rmed?	death?	mpletion of cause of
V It	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?	Hospital:			1000	26. Place of Deat				
of	ig Phys ter this neral dir		1 Yes 2 No  27. Magner of Death	28a. Date of Injur (Month, Day		R/Outpatient 28b. Time of	3 DOA Othe	4 Li Nursing Ho	ome 5 Residence 28d. Describe h			(5)
ë	Attending death. ctor: After y the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Injury Work M 1 🗀	(? Yes 2 □No	254. 563611561	iow injury occ	ulled	
N ivis	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At hom	ne, farm, stree	t, factory, office		28f. Location (S City or Tox	Street and Nur	mber or Rura	al Route Number,
, ο	ors af									,		
	24 hos	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Example 1	rsicien: To the best of iner: On the basis of and manner sta	examination	ledge, death o on and/or inves	ccurred at the time stigation, in my op	ne, date and place, pinion, death occurr	and due to the or	cause(s) and date and place	manner as s	tated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Me	29b. Signature and title of certifier	An An	160.		29c. License			29d. Date sigr		
	^		I Juan Joor	An Mb			89	1527		9/10	104	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	1)		30. Name and address of person who co	ompleted cause of de	ath (Item 2	/ 1/ /	1 /	70000	1	1/10/	1	
			31. Date filed (Month, Day, Year)	M. D. 9	0 /	1	land t	teneral	403	10 Tal		
	Sta Registr		SEP 2 0 2004	Medistra	s signatu	house			,			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 15 2004 **Physician** Scotember Gregory /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKIN timore 'ear | If Under 24 Hrs. Da 5. Social Security Number 8. Date of Birth Birthplace (State or Fereign Country) 7. Age (In yrs **Funeral** Months Days Hours 2□ € Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. or items 23e or 28e-f show out: If item 27 is marked other than "neturel", or items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits State 10b. Count th and Mental Hygiene. 27 is marked other than "neturel", or items 23e or 28e-f show treumatic event, the Madical Examiltar roust be notified at ¶Yes 2 No Completed by Funeral Director Street and Number 10f. Zip Code 10g. Citizen of What Country? ON 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?

1 Yes 2 Your Year or Dates: Black, White, etc. 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1□Yes 2No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) condary (0-12) College (1-4or 5+) Elementary/Sec SUBJEI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Namp/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cly or Town, State, Zip Code) 20b. Place of Disposition (Name of acemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State perr it. Pages 1 Department of H Importent: If ite any injury or ot 1 Burial 2 Cremation 3 □Removal from State MARY 5 Other (Specify) \* 4 ☐ Donation 21. Signature of Fu Fral Service Licens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 2 X No 2 No 1 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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Mr 2 Uls 43

31. Date liled (Mong Pap Ygar 0 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Honistran's Signatur

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JOHNS HOMEINS HOSPITAL TOMOGINO DOLTONS LOUNCE GOD NEED WILFE STREET BACTIMENE NO 21287

SEPTEMBER 16 2004

				State of Maryl	•	artment of F rtificate of		, ,	ene g. No. 1	2000			
	Physic	ian	Decedent's Name (First, Middle, L     MARGARET		ν			2. Date of Death	Day Year	3. Time of Death			
-	/Medi Examir		4a. Facility Name (If not institution, gi		N		lb. City, Town, or	Location of Deeth	4c. County of Deeth	5:10A17			
1	LAGIIII	ici	Roland Park P				Baltim	ore	N//				
	Funeral Director		219-10-6288	Sex 7. Age (In )	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Dex.) OCTODER 22	9. Birth Cou , 1907 Mary	place <i>(State or Foreign</i> ntry) y l and			
	/land		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or Lo	cation				10d. Inside City Limits			
	e-f sh	cto	Maryland N/a		Baltimo	re				YYes 2 No			
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of Whet Cou	ntry?			
	sath w	eral	830 West 40th St		110	2121			USA				
020	urs after de it, or Item Sandiner	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1	l l	Vas Decedent of H i Yes, specify Cuba I□Yes XX No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify:				
21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	iducation ede completed) College (1-4or 5+)		lent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor )	king 10	6b. Kind of Business/In				
	a filed al Hyg other	BeC	17. Father's Name (First, Middle, Las		HOH	ICHIONEI	18. Mother's Nar	ne (First, Middle, Ma	OWN Ho	me			
ylaı	2 should be filed v and Mental Hygie is marked other t aumatic event, It	70	Summerfield Bens	on			Lai	ura Jane S	Shipley				
Maryland	12 sheh and hand risma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)  Lewis A Beck Husband 830 W 40th St Baltimore, Maryland 21211										
	s 1 and Health tem 27 other tr		20a. Method of Disposition	201		sition (Neme of netory or other place			Dc. Location - City or To	own. State			
m <sub>0</sub>	Pages nent of I nnt: if ite iry or o		X Burial 2 Cremation 3 C 4 Donation 5 Other (Speci			ge Cemete	ery (		ikesville,				
Baltimore,	permit. Pages 1 and Department of Health important: if item 27 any injury or other tr ance.		21. Signature of Funeral Service Lice	Man Mon a	hin) 22	Name and Addres	- 1417		lefeld Funeral				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.										
>	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a arkning		ic care		enlar c	į	Onset and Death			
	p ti	iner		b	o (or os a conseq	derice or).			}				
60,	ificate be executed g physician and es the burial-transit	al Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a consequ	uence of):			-				
Box 68760,		n/Medical	resulting in deeth) Last	Due to	o (or as a consequ	ience of):							
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on of	Attending Physic death.  ector: After this by the funeral d	ation: T	27. Menner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Dey Year)	28b. Time of	28c. Injury Work		28d. Describe how		//			
Division	al or Attending P s after death. Il Director: After i	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		t home, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Rure Stete)	l Route Number,			
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edicai	29a. Certifier (Check only one)  1	nysicien: To the best of my k niner: On the basis of exami end manner stated.	nowledge, death ination end/or invi	occurred at the timestigation, in my op	e, date end place, inion, death occur	and due to the caus red at the time, date	se(s) and manner as sto and place, and due to	eted. the cause(s)			
<b>1</b>	To t To t	Σ	29b. Signature and title of certifier  M. Habelle	mac greg	ion or D	29c. License			Date signed (Month, L Pfember 18				
,	10		30. Name and address of person who TS ABELLE MA	completed cause of death (It	tem 23a) (Type, F 0 W 40			DORE, OT	21211	1			
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature								

DHMH 16 Rev 6/95

			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 0 14	29639
	Physici /Medic		Defression 18 200	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)  NOLTHWEST LEOSPITAL CENTER RANDALLSTOWN  Ac. County of Death RANDALLSTOWN  AC. County of Death RANDALLSTOWN	
	Funeral Director		0.4.0 0.0 0.0.4.5 1	ice (State or Foreign y) CAROLINA
	ith the Maryland or 28a-f show	Director		d. Inside City Limits 1 ☐ Yes 2 ☐ No y?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. itam 27 is marked other than "natural; or Items 23e or 28e-f show other traumetic event. Its Modical Examples motified a	by Funeral	21 ELDERBERRY COURT 21228 USA  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, etc. 15. Never Married 2 Married 3 Widowed 4 Divorced 16. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Specify: BLAC	c.
121215-0036	filed within 72 hc Hygiene. other than "natur ant, in Medical	Completed		•
Maryland	2 should be f and Mental I is markad of sumetic ava	To Be		Pada
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		DEBORAH C. ALSTON/DAUGHTER 5801 WAYCROSS RD, BALTIMORE, MD 21  20a. Method of Disposition    Date   Date   20c. Location - City or Town	MD E 21207
}	Physician /Medical Examiner	er	Immediate Cause (Final disease for condition resulting in death)  Sequentially list conditions  b.	Approximate nterval Between Onset and Death
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last   C. Due to (or as a consequence of):  d.	
P.O. Box	at the death certifical by the attending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	ay Year
	requires that sen signed b rould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1
Vital Records,	: The law recate has been page 2 sho	Completed	CONGESTIVE HEART FAILURE  24a. Was an autopsy performed? performed? 1 Yes 2 No 1 Yes 2	y findings available oletion of cause of
o	Mtanding Physician: The death. ctor: After this certificate his the funeral director, page	atlon: To Be	examiner?  1   Yes 2   No	
Division	ial or Attend s after death al Diractor: /	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural F	Route Number,
	To the Hospital or Attending within 24 hours after death.  To tha Funeral Diractor: After completely filled in by the fune	Medical (		ed. ne cause(s)
)	To 1 To 1	Σ	D42723. SEPTEMBERIG	2004
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST I HOSTIT AL CEST AVVERALLI M KM RISH. 5401 DLD COURT ROAD MI	21133
	Sta Registi		A CONTRACTOR OF THE PROPERTY O	

		•	For State Registrar	State of Maryland		tment of F		-	giene	101. 5	29640
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last ROBERT, 4a. Eacility Name (If not institution, give	street and number)	2	OGC 4b. City, Town, or Bull M	r Location of Death	ty	Day MOE 4c.	County of Death	
	Funeral Director		155-28-5834 Usual Residence of Decedent	M 2□F 66	Yrs.	Months Days	Hours Min.	8. Mate of Bir (Month, Da	y, Year)	9. Birth Co.	nplace (State or Foreign untry) NJ
	the Marylan r 28a-f ehow notified at	Director	10a. State 10b. County  PA Monroe  10e. Street and Number	-	Town or Loca	tion oudsbur 10f. Zip Code	'g		10g. Cit	izen of What Cou	10d. Inside City Limits 1 XYes 2 □ No
36	72 hours efter deeth with the Maryland naturel', or iteme 23a or 28e-f ehow insel Examilian et ouel be notified at	Funeral	504 Mulberry Co	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 ☐ No If Yes, Give		183 as Decedent of H res, specify Cuba	Ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)		U . S . A .  14. Race - Amer Black, White	ican Indian, n, etc.
21215-0036	s within jiene. r then "	Completed by	15. Decedent's Edi (Specify only highest grade	Year or Dates:  Jugation Je completed)  College (1-4or 5+)  na	(Give kir	nt's Usual Occup nd of work done of NOT use retired	durina most of work	king	Mai	nd of Business/li ntenan ulatio	ce
Maryland	d ta b	To Be C	17. Father's Name (First, Middle, Last)  Natale Foglia  19a. Informant's Name/Relationship (T	урө, Print)	19b. Mailing	Address (Street	18. Mother's Nam Louise and Number or Ru	Carfac	no	,	ip Code) 18301
Baltimore, M	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 fe marke any injury or other traumatic 90008.		Sara Foglia-Wi  20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation XXOther (Specify)  21. Igniture of Funeral Service Licens	Removal from State  Entombment G	ace of Disposit metery, crema arden	ion (Name of tory or other place of Men	nories 9	Date 9/22/04	20c. Lo	shingt	urg, PA
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8760,	ate be executed hysicien and the burial-transit	dicai Examiner	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ence of):						
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Vital Records,	The ate h page	e Completed	25. Was case referred to medical				26. Place of Deal	1 ☐ Yes	rmag? 2 No	24b. Were auto prior to co death? 1 \( \sum Yes	opsy findings available ompletion of cause of
of	ing Physic	ation: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ALTER OF THE STREET	ER/Outpatient 28b. Time of Injury	3 DOA Otho 28c. Injury Work	4   Nursing H	ome 5 Resid	_	S □Other (Speci y occurred	fy)
Division	itei or Attend irs etter death rei Director: , led in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)				City or Tov	vn, State	)	al Route Number,
	To the Hospitei or within 24 hours etter To the Funerei Dire completely filled in b	Aedical	one) 2 Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	rledge, death o on and/or inves	stigation, in my or	pinion, death occur	red at the time,	date and	place, and due t	o the cause(s)
	Viti	Σ	29b. Signature and title of pertifie	mo		29c. License		1 -6-		e signed (Month,	
	10		JENNY TI	ompleted cause of death (Item	23a) (Type, Pri	IOLFE	STREE	27. B	ACT1.	MORE,	2007 MD 21287
	Sta Registi		31. Date filed (Month, Daf, Year)  SFP 2 0 2	32. Registrar's Signatu	J. A	me					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yee **Physician** SEPTEMBER 17, ELIZABETH L. GRANER 2004 6:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE TOWSON TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☐ X 2/24/1921 Director 212-12-1592 83 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at BALTIMORE CARNEY 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9136 COVERED BRIDGE ROAD 21234 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE ρ 3 □XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Obejectment of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, the Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) 10TH GRADE ANESTHESIOLOGIST ASSISTANT HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JEREMIAH HATTER LOUISA F. HARTMANN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9136 COVERED BRIDGE ROAD BALTIMORE, MD 21234 CHRISTINE L. GRANER DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \*4 □Donation 5 □ Other (Specify) METRO CREMATORY, INC. 9/20/2004 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 1120 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 1 Camer 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician antrem /Medical resulting in death) Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 poinths?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ nobele 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 727565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 Greene Tree Rd eman Milen 21208 32. Registrar's Sonature 31. Date filed (Month, Day, Year) State SEP 2 0 2004 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
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			For State Registrar	•	epartment of Health and M Certificate of Death	lental Hygie Reg.	2001	29612
	Physici	an	1. Decedent's Name (First, Middle, Last)	. Goldsborough	Tw	2. Date of Death Month	Day Yeer	3. Time of Death
Ē	/Medic Examin	al	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	Suptember 1	4c. County of Death	3.08 FM
			Sinai Hospital	of Balhmore	Balhmore Ci	h	N/A	
ı	Funeral Director		5. Social Security Number 212-58-0013 6. Sex	M 2□F 7. Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth (Month, Day, Ye 05-24-1	ar) Coun	lace (State or Foreign etry)
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location		1	0d. Inside City Limits
	e-f sho	ctor	Md N/A	Bal	timore			1 AYes 2 No
	with the or 28	Dire	10e. Street and Number 4313 Kennison A	Vonuo	10f. Zip Code		Citizen of What Coun	try?
	death	Funeral Director			21215  13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	S.A.  14. Race - Americ Black, White, e	
36	within 72 hours after death with the Maryland ene. then "naturel", or Itams 23e or 28e-f show then "Medical Ers inher must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1  Yes 2 ★No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	110211, 010.)	Specify Blac	
215-0036	72 hou 'nature	eted	15. Decedent's Educ (Specify only highest grade	cation 16a. De	ecedent's Usual Occupation Give kind of work done during most of work	ing 16b	. Kind of Business/Inc	
2121	l within iene. r then '	Completed	Elementary/Secondary (0-12) 11 years	College (1-4or 5+)	fe. DO NOT use retired) SSIONS CONTROL T	ech. St	ate of M	arvland
	be filed stal Hygi of other event, I	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	First, Middle, Maid	den Sumame)	<u>ur / runu</u>
Maryland	should Ind Men marka	2	19a. Informant's Name/Relationship (Type	ldsborough Sr.	Hett.  Mailing Address (Street and Number or Run	ie Willi		Code)
	1 and 2 : Health ar tem 27 le		Karen Harris-Go	ldsborough 43	13 Kennison Ave.	Balto.,	MD 21215	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 le markad other then "naturel", or Itams 23a or 28e-f show any injury or othar treumatic event, the Medical Erantral be multical anone.		20a. Method of Disposition  1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	emoval from State cemetery,	crematory or other place)		Location - City or To	
altin	permit. P Departme Importen any injur)		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fundral Service Lice > 6		22. Name and Address of Facility		tonsvill	
m m	88 5 5		23a Bart Star the disease or compli	well of	4600 Liberty He		e.Balto.	, Md21207
	Physician		shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.	lung Cance			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):		<u> </u>		
	_xammer	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	:			
	ecuted and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or see a second of)				
58760,	icate be executed physician and s the burial-transit	dicalE	L <sub>d</sub>	Due to (or as a consequence of):				
_		<b>w</b> 1	IF FEMALE:					
Вох	The law requires that the death certificate has been signed by the atlending planes 2 should be detached for use as to	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
P. 0.	at the de	Phys	9 □ Unknown	9□ Unknown		no. Bidad		
	uires that signed t	by	Part II. Other significant conditions con	ributing to death but not resulting in th	ne underlying cause given in Part i.		co use contribute to th	
Records,	e ław requir has been si je 2 should	Completed				24a. Was an autopsy		osy findings available inpletion of cause of
						performed 1 ☐ Yes 2 🛣	? death?	2₩ No
f Vital	Attending Physicien: or death. ector: After this certification in the funeral director.	To Be	25. Was case referred to medical examiner?  1 Tes 2 No	ospital: 1 ☑Inpatient 2 ☐ ER/Outpa	Other	n (Check only one) me 5 ☐ Residence	6 ☐Other (Specify	0
on of	ding Ph h. After th funeral	lon:	27. Manner of Death 1 K Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim		28d. Describe how in	njury occurred	
Division	Attencer death rector: by the	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm		28f. Location (Street City or Town, St	t and Number or Rural	l Route Number,
	urs afte	0		building, etc. (Specify)				
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one)  1 ☑ Certifying Phys 2 ☐ Medical Examir	ician: To the best of my knowledge, der: On the basis of examination and/o and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	i(s) and manner as sta and place, and due to	ated. the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	MO69 000	29c. License number		Date signed (Month, L	
	<b>\</b>		30. Name and address of person who co.	mpleted cause of death (Item 23a) (To	Res-000		ptember, 12.	2009
	(	9	KHAWAJA-A	FAROOD SIV	an Hospital of	Baltimo	ne	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 2	304 Slowe #	My Hospital of			

**Physician** /Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. P.O. F cate has been signed by page 2 should be detact Division of Vital Records,

Examine Physician/Medical ģ Completed director Be မ Certification:

**Physician** 

/Medical

**Examiner** 

Funeral

Director

rai', or itema 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after c nent of Health and Mental Hygiene. nnt: If item 27 is marked other then "natural", or iter

traumatic evant, the Medical

Department of H Important: If ite sny injury or of once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

with the Maryland

certificate the Hospital or Attending Physician: this After this funeral d hours after death. Diractor: within 24 hours a To the Funeral L Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier l 🐔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier Amatin H Melecen MD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 Dolbhin MAFEM AMATUH M 31. Date filed (Month, Day, Year)

State

Registrar SFP 2 0 2004 32. Registrar's Signature

			For	State of Mary				d Mental Hy	giene	
			- State Registrar		Ce	ertificate of	Death		Reg. No. 1	2061.1.
	Physici	an	Decedent's Name (First, Middle, Last	θ				2. Date of Dea	Day Yee	3. Time of Death
	/Medic			Ernest	Gaithe			Septemb		
	Examin	er	4a. Facility Name (If not institution, give SINAL HOSPITAL		IMORE	Balton		ity	4c. County of De	ath
	Funeral		5. Social Security Number 6. Se	Yu one	yrs. last birthday	) If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Da	y, Year)	irthplace (State or Foreign Country)
	Director		237-14-0037 Usual Residence of Decedent		89 Yrs.			3-3-1	.915	S.C.
	/land		10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Man a-f sh	tor	Md N/	A	Balto					1 X Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a unit b	ral	3001 Brighton	Street		21216			USA	
	er des	Funeral	11. Marital Status	12. Was Decedent Ever Amed Forces?	r in U.S. 13	Was Decedent of H If Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race · Ar Black, WI	nerican Indian, nite, etc.
36	rs aft	by F	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed 4 ☐ Divorced	1 XXYes 2 ∏ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: B	Lack
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 show tha Midical Examiner must be multified at	ted	15. Decedent's Edu	ucation	16a. Dec	edent's Usual Occup	ation		16b. Kind of Busines	s/Industry
2	hin 73	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Giv	e kind of work done of DO NOT use retired	during most of v	vorking	Wareho	,
2	filed wit Hygiane other the	Com	5th grade	N/A	Tru	ck Driver				
pu	be filed within 72 hours after death with the Marylan stal Hygiane. od other than "natural", or items 23a or 28a-f show event, the Macical Examiner must be multiled at	Be	17. Father's Name (First, Middle, Last)  John Gaither					lame (First, Middle,		
<u>}</u>	2 should be filed withir and Mental Hygiane. is marked other than anmatic event, the M	To						beth Hall		
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic es		19a. Informant's Name/Relationship (T)		I Decision				r, City or Town, State	
	1 an Heal tem 2		Ruth Gaither - W: 20a. Method of Disposition		Ob. Place of Disp	osition (Name of		et Balto	Md 21216	
<u>o</u> E	Dages ent of nt: if if		1XXBurial 2 ☐ Cremation 3 ☐ I		-	ematory`or other plac Park Ceme		20-2004	Balto, mo	
Baltimore,	mit. Partm partm portar / injui		21. Signature of Funeral Service Licens	1		2. Name and Addres				
m	9 0 m m 0	1	Nala M	asel		4300	Wabas	h Avenue	Balto, Md	21215
			23a Part 1. Enter the disease, or composhock, or heart failure. List only of	lications that caused the	death. Do not er	nter the mode of dyin	g, such as card	iac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Status	<del>-</del> - 2	ep ticus				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co						2003
П	LAGITITICI	<u></u>		b. Due to (or as a co	Control of the Contro					
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to for as a co	nisequantee ory.					
Ć,	icate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last	c.  Due to (or as a co	nsequence of):					
68760,	sicia Psicia e bur	edical		d						
_		Medi		=======================================		-30%			1	
Box	eath certifi attending for use as	lan/M	230. Was decedent pregnant	23c. If yes, outcome of pr		□Ectopic pregnancy			23d. Date of d	
Ш	law requires that the death certil as been signed by the attending 2 should be detached for use a	O	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown		Other (specify)			Month	Day Year
P.O.	res that the de igned by the a be detached t	Phys	Part II. Other significant conditions co	entributing to death but no	nt resulting in the	Inderhina cause alv	on in Part I	23e Did to	hacco use contributo	to the cause of death?
Division of Vital Records,	signe d be	d by	, <b></b>	The state of the s	or rooming in the	andonying dadad give	on and a			Probably 4 Denknown
Sor	w require been sign	Completed						24a. Was a		autopsy findings available
Re	0 - 0	dmc						- autop perfor	sy prior to med? death?	completion of cause of
ta		a	25. Was case referred to medical				26. Place of D	1 ☐ Yes eath Check onl or		s 20 No
<u> </u>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Othe			ence 6 Other (Sp	ecify)
0 0	Attending Physician: or death. ector: After this certification of the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Ye	ar) 28b. Time	of 28c. Injury Work			ow injury occurred	
sio	tendi eath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			M 10	Yes 2 □ No			· ·
<u>∑</u>	= = -	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s Specify)	reet, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
_	To the Hospital of within 24 hours af To the Funeral D complately filled in		29a. Certifier 10 Certifying Phy	sician: To the best of m	v knowledne dos	th occurred at the tim	ne date and nia	ce, and due to the o	Auso(s) and masses	as stated
	e Hos 24 h Fun lately	edical	(Check only 2 Medical Exami	iner: On the basis of exa and manner stated.	mination and/or i	nvestigation, in my or	pinion, death oc	curred at the time, o	date and place, and du	e to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (Mor	
•			K.A. Zama	n, MD		RE	5-00	0	September	16,2004
	3		30. Name and address of person who co			Print) HOSPITAL	- OF	BALTIMD	RE	
	Sta		31. Date filed (Month, Day, Year)	32 Bahistrar's 9				, .		
	Registr	ar	SEP 2 0 20	104	15					

.5			riedse i	State of Maryl	and / D		nt of H	ealth and l	Mental Hy	giene	ole.	- 1 m
,	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  1 A & L  4e. Fecility Name (If not institution, give s  1. Decedent's Name (First, Middle, Last)  4. Fecility Name (If not institution, give s	1 1 1		+A!			2. Date of De Month  Location of Death  Bil Vivi	Day 14 2	Year /	ime of Death 437
	Funeral Director		5. Social Security Number 6. Sex 214–42–6339		yrs. Tast birth	nday) If Und Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Nov • 1	y, Year) 8,1944	9. Birthplace (S Country) Marylar	State or Foreign
death with the Maryland	8a-f show olified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD Anne Aruno		City, Town	oolis	,				10	side City Limits
	al', or itams 23a or 28a-f show Examiner must be notified at	Funeral Dire	10e. Street and Number  2706 Summerview Wa  11. Marital Status	2. Was Decedent Ever in			ip Code 21401 edent of His		pecify Yes or No o Rican, etc.)	10g. Citizen of V US.	A se - American Ind	ian,
-UUZU hours efter	tural', or ita al Examine	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Educ	Armed Forces?  120 Yes 2 No If Yes, Give Year or Dates: 19	-	ir Yes, sp 1 ☐ Yes Decedent's Us	2 <b>X</b> №	Specify:	o Hican, etc.)	Specify	MITTE	:e
C Z Z Z Z D filed within 72	giene. er than "nel ; the Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	completed)  College (1-4or 5+)	- (	Give kind of w life. DO NOT Lspatch	vork done d use retired)	uring most of wor	rking		usiness/Industry more Tan	ık Line
rylan	d Mental Hy narked oth natic event	To Be (	17. Father's Name (First, Middle, Last) William Alexinder  19a. Informant's Name/Relationship (Typ.		104	Mailing Addres		Jenoui	ne (First, Middle, se Varne	У	ne) State, Zip Code)	
more, ma Pages 1 and 2 sh	nt of Health If Item 27 or other tr		Gerald S. Hoover  20a. Method of Disposition  1□ Burial 2★ Cremation 3□ Re	(Brother) 20 emoval from State	260 b. Place of I	06 Nort Disposition (Nort, crematory of	h Wes	st 64th (	Terr., G 9-17	ainesvi 20c. Location -	11e, FL City or Town, St	32606
Daltimo			4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Metro		and Address lesty	s of Facility Funeral	Home, P	.A.	ore, MD D 21401	
ا/ يتم	nysician Medical kaminer		23a. Part1. Enter the disease, or compile shock, or heart failure. List only one limmediate Cause (Final disease or condition resulting in death)	Acu te  Anterior		•					Interv Onse	oximate al Between t and Death
<b>68 / 50,</b> ifficete be executed	g physician and as the bunel-trensit	ledical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due t	o (or as a co	posequence of	):	Her	art L	Disea	SR	
ords, F.O. Box 68 requires that the death certifice	ed by the ettending phy deteched for use as th	Physician/Med	Part II. Other eignificant conditions cont	ributing to death but not	resulting in	the underlying	cause give	n in Part I.		tobecco use con	ntribute to the ca	ause of deeth? 4資Unknown
ecords, law requires t	ss been signed by the e 2 should be deteched	Completed by								en autopsy rmed?	24b. Were aut available completic of death?	opsy findings prior to on of cause
	page	Be	25. Was case referred to medical examiner?	- acital.			Ollo		1 □ \ath (Check only c		1 □ Yes	2 No
	within 24 hours efter death.  To the Funeral Director: After this o completely filled in by the funeral directions.	Certification: To	27. Manner of Death  1 SNatural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year	2 ZNER/Outp 28b. Ti (n)		28c. Injury Work	4 Li Nuising F	lome 5 Resident	dence 6 □Oth now injury occuri		
DIVIS	nours efter de neral Directo y filled in by t		3 Suicide 4 Could not be determined  29a. Certifier 1 Certifying Physi	28e. Place of Injury - A building, etc. (Sp	ec <i>ify)</i> knowledge,	death occurre	d at the time	e, date and place	City or Tow	vn, State) cause(s) and ma	per or Rural Route	
To the Ho	within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examin  29b. Signature and title of certifier	er: On the basis of examand manner stated.	ep u	or investigation	on, in my op	inion, death occu	rred at the time,	date and place,	and due to the ca	
	6		30. Name and address of person who core	npleted cause of death (	(Item 23a) (T	Type, Print)	51	Imer	ica	210	35	
	Sta Registi		31. Date filed (Month Pay Year) 0 200	4 32 Anaistrar's S	ignatu	HOSAL						

			Amend item #4a,10e,	or Print in Black l	20/.UT LI	Ensure All	Copies Are	e Legible.	
	•		For Amend Item 5 per   State   Registrar	ffi, g866,04/27	of the control He entiticate of D	ealth and Me Death	ntal Hygier Reg. t	2001	29616
	Physici	an	1. Decedent's Name (First, Middle, Last)	40		2	2. Date of Death	Day Yejar	3. Time of Death
	/Medi Examir	al	4a. Facility Name (If not instituting give street)	nd number)	4b. City, Town, or L	Location of Death	9-14	tc. County of Death	) / CODAM
1		Ŭ.	3601 Lambe	the kec	Bal	to			
I	Funeral Director		5. <b>371-106-2-14 NO 1175</b> 6. Sex 1 <b>X</b> M 2E	7. Age (In yrs. last birthda Yrs.	y) If Under 1 Year Months Days	Hours Min.	3. Date of Birth Month Day Yes	39 M. Birth	nplace (State or Foreign untry)
	iand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	with the Maryland a or 28a-f show Le notified at	Director	MD	Balt	imore	J			1 <b>X</b> Yes 2 □ No
	th with th	I Dire	10e. Street and Number Labyrint	Dood	10f. Zip Code	15	10g. 0	Citizen of What Co	untry?
	dead dead	Funeral	Am	ed Forces?	3. Was Decedent of His If Yes, specify Cuban	panic Origin? (Speci , Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
920	urs afte	by	1 ☐ Never Married 2 ☐ Married 1 ☐ If Ye Yea	Yes 2 No is, Give r or Dates:	1 ☐ Yes 2 📈 No	Specify:		Specify: A	ack
21215-0036	within 72 hours after ene." then "natural", or Ite re Modical Exaculte	leted	15. Decedent's Education (Specify only highest grade compl	eted) (Gir	cedent's Usual Occupative kind of work done du	ion iring most of working	16b.	Kind of Business/I	ndustry
212	filad withir Hygiene. ther than int, II e M	Completed	Elementa (y Gecondary (0-12) Coll	ege (1-4or 5+)	1	apro		Balto	Cety
and	W day	Be	17. Father's Name (First, Middle, Last)		1	18. Mother's Name (	First, Middle, Maide	en Sumame)	
Maryland	id 2 should bith and Ment th and Ment 27 Is marks 17 Is marks	٦ ر	. Informant's Name/Relationship pe, Prh	Daughter 19b. Ma	iling Address (Street an	nd Number or Rural I	Route Number, City	or Town, State, Z	ip Code)
	s 1 and 2 of Health item 27 I other tre	(	909/e. L. Hewi	20b. Place of Dis	Ψ2. W· position (Name of	Cervina	100 St	Location - Ity or I	06 MD 2/223 own, State
altimore,			1 Derial 2 □ Cremation 3 □ Removal 14 □ Donation 5 □ Other (Specify)	from State cemetery, cr	rematory or other place)	ok G-2	y-04"	Robe 1	(MA)
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	17.37	Name and Amess	C. Trees	of Frence	neseri	ies
ī			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not e	4905 Uniter the mode of duing,	uch as cardiac or r	respiratory arrest,	40/MJ	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	100	· n C	wher			Onset and Death
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68760,		dlcal	d						
Box 6	leath certificate to attending physical afor usa as the b	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If ye	s, outcome of pregnancy				23d. Date of deliv	/ery
	it the death by the atte tached for	Physician/Medical	in the past 12 months?		B ☐ Ectopic pregnancy i ☐ Other (specify)			Month	Day Year
, P.O.	tha de de	by Ph	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given	in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ords	w requires been sign should be	ted b					1 Yes	2□No 3□Pro	bably 4 ∐Unknown
Rec	The law cate has b page 2 st	Completed					24a. Was an autopsy performed2	death?	opsy findings available ompletion of cause of
Vital Records,	ician: Th certificate ector, paç	Be Co	25. Was case referred to medical examiner?			26. Place of Death	1 □ Yes 2 □ N Check on _one	lo 1 □ Yes	2□ No
	Phyaici r this cer ral direct	0	1 Yes 2 No Hospital:	1 Inpatient 2 ER/Outpati Date of Injury (Month, Day Year)  28b. Time Injury		4   Nursing Home	5 Residence	6 ☐ Other (Speci	(y)
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Divis	l or Att	ertific	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	281	f. Location (Street a City or Town, Sta	and Number or Rur te)	al Route Number,
	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certification by the funeral director.	calc	29a. Certifier Certifying Physician:	o the best of my knowledge, deathe basis of examination and/or	ath occurred at the time	, date and place, and	due to the cause	s) and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical	one) and 29b. Signature and title of certifier	manner stated.	29c. License r			rate signed (Month,	
	L 2 F 0		· DI My	<b>~</b>		D4085		A .	2009
	4		30. Name and address of person who completed	1		Paul PI	Baldi	70/Y Z	120 2
	Sta	te		32. Registrar's Signature	broke		-		

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1tem # 4a, 10e, per Phy FH, G835, 9/27/04 TT
State of Maryland, Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Sept.  $15^{Day}, 2004$ **Physician** 9:30p. M Bessie Elizabeth Hults /Medical 4a. Facting 40 (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7304 Brightside Road Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 15,1914 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🛱 F Oct. 89 Director 214-03-2221 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural, or items 23a or 28a-f showing the Modical Examiliar and be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7340 7304 Brightside Road 21212 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Merson Bessie Jenkins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If item 27 is 7340 Brightside Road Baltimore, Maryland 21212 (Daughter) Linda Merrick 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of important: if any injury or once. 9/18/04 Dulaney Valley Timonium, Maryland of Funeral Service Licensee Mitchell-wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AlzHEIMERS Pnysician DEMENTIA 10 4EMS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriat-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 4☐ Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: filled in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 050760 9/16/04 tentes Wen M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) York Rd. LUTHERY11e MO 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 0 2004

		-	For Stete Registrar	State of Maryland /	Department Certificate			giene Reg. No. () () (	29648
	Physici /Medic		1. Decedent's Name (First, Middle, Last,		PREIZA		2. Date of Dea	Dayl 2004	3. Time of Death
	Examin Funeral Director	er	North West Hospita  5. Social Security Number  215-50-9314	Center 7. Age (In yrs. last b	Ran	dallstow 1 Year   If Under Days   Hours	10. 24 Hrs. 8. Date of Birt Min. (Month, Da		plece (State or Foreign htry)
	0	tor	215-5U-9314		wn or Location		Feb. 1	,1911   Sici	1y l0d. Inside City Limits 1 ☐ Yes 2 🙀 No
	with the	Director	10e. Street and Number		10f. Zip (	Code		10g. Citizen of What Cour	ntry?
036	ges 1 and 2 should be illed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If of Health and Mental Hygiene.  If item 27 is marked other than "natural", or iteme 23a or 28a-f show if item 27 is marked other than "natural", or item 23a or 28a-f show or other traumatic event, the Madical Evaluation must be notified at	by Funeral	7500 Sudbrook Road  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	13. Was Decede If Yes, speci	rfy Cuban, Mexicar	gin? (Specify Yes or No h, Puerto Rican, etc.)	USA - 14. Race - Americ Black, White,  Specify: Whi	etc.
Maryland 21215-0036	filed within 72 ho Hygiene. Other than "naturi ant, the Medical I	Completed	15. Decedent's Edu (Specify only highest grad	e completed)  College (1-4or 5+)	a. Decedent's Usual (Give kind of work life. DO NOT use Omemaker	k done during mos	t of working	16b. Kind of Business/In	
/land	ouid be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Guiseppe Glorioso		Smemarer		er's Name (First, Middle, fina Glorio:	Maiden Sumame)	
	nd 2 should and Men 27 ie marke r traumatic		19a. Informant's Name/Relationship (T)  Joseph Incapera				er or Rural Route Number eisterstown	er, City or Town, State, Zip Md 21136	Code)
altimore,	permit. Pages 1 and 2 Department of Health Important: if Item 27 i any injury or other tre ance.		20a. Method of Disposition  **X**Surial 2 Cremation 3 F  **4 Donation 5 Other (Specify)	20b. Place cemet	of Disposition (Namery, crematory or other	e of her place)	Date	20c. Location - City or To	
Balti	permit. I Departm Importal any inju		21. Signature of Funeral Service License		22. Name and	Address of Facili	11824 Re	eisterstown stown Md 211	Road
F	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heartaining. List only of Immediate Cause (Final disease or condition resulting in death)	CEREBR	o vascu			rrest,	Approximate Interval Between Onset and Death
8760,	cate be executed which solves and purial-transit the burial-transit and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	CONC (	CEREROZ	o MSOVAIZ	DISANÉ	YEARS
P.O. Box 6	ne death certiff the attending hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal deal 4  Pregnant at time of death 9  Unknown	th 3 □Ectopic pre 5 □ Other (spe			23d. Date of delive Month	ery Day Year
rds, P	w requires that the been signed by should be detact		Part II. Other significant conditions co	_	in the underlying ca		0./	obacco use contribute lo t Yes 2 No 3 Prot	he cause of death?
Division of Vital Records,	: The law re cate has be page 2 sho	Completed by							opsy findings available impletion of cause of 2 No
	ysician: The l is certificate ha director, page	To Be	25. Was case reterred to medical examiner? 1 ☐ Yes 2 ☐ Ne	lospital:	Outpatient 3 DO	Othor	of Death (Check only oursing Home 5 Residual	one) dence 6 □Other (Specil	(v)
o noi	anding Physiath.  or: After this he funeral dia	ertification: 7	27. Manner of Death 1\□Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of 28 Injury M	Bc. Injury at Work?	28d. Describe f	how injury occurred	
Divis	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificy completely filled in by the funeral director,	O	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			City or Tou		
	ne Hosp n 24 hou ne Fune detely fi	edicai	29a. Certifier 1 ♣ Certifying Phy (Check only 2 ★ Medicel Exam	sician: To the best of my knowled- iner: On the basis of examination a and manner stated.	ge, death occurred a and/or investigation,	at the time, date ar in my opinion, dea	nd place, and due to the oth occurred at the time,	cause(s) and manner as s date and place, and due to	itated. o the cause(s)
	To the To the Complet	M	29b. Signature and title of certifler  29b. Signature and title of certifler  30 Name and address of person who of AMASWAW I.  31. Date filed (Month, Day, Year)  SEP 2 0 200	you MD	29c.	License number MD 54	288	29d. Date signed (Month,	Day, Year) 2004
	A		30 Name and address of person who of RAMASWAWY I	ompleted cause of death (Item 23a	(Type, Print)	Twest 1	tospital (	exte,	
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 0 200	32 Registrar's Signature	brash ?		•		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 10:10 PM SEROW SEPTEMBER 16,2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** BWYNUMORE AVE. 2716 ALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 1 F 371-52-658 Yrs SEPTEMBER 16,1997 GERMANY Director Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10a State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director RALTIMORE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WYNIMORE 238 2716 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 0 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administrator BALFIMORE City Schools YEAR COLLEGE of Haalth and Mental Hygie fitam 27 is marked other t r other traumatic avent, II 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be SAMUEL ANNIE ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (HUSBAND) 2716 GWYNNMORE AVE, BALTIMORE, MD 21207 SEROW LAWRENCE. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of H Important: If ita any injury or otl once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK 09-23-2001 BALTIMORE, MARYLAND <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOWSE
DIYO N. FULTON AVE, BALTIMURE, MARYLAND 21217 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ntarcti 10 cavel Priysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner and I-transit The law requires that the death certificate be axecuted burial-t Box 68760. nding physician use as the buria Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 certificate Division of Vital the Hospital or Attanding Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 H sidence 6 Other (Specify) 1 Yes 2 No 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 ☑Natural 5 Pending 1 ☐ Yes death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide within 24 hours after To the Funaral Direct Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ownes Mills, and 5 #200 Saba Park Oamper 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -3 Time of Death Month SEPT. Physician 16, 2004 ROBERT KNIGHT 4:20 AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner JOSEPH RICHIE HOSPICE BALTIMORE CI N / A 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday). Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **X**□M 2□F Yrs Director 219-18-7049 03/12/1925 Ν. CAROLINA Usual Residence of Deceden with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 1√2 Yes 2 □ No Director MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2912 GRANTLEY Itams 23a ROAD 21215 Completed by Funeral USA 12. Was Decedent Ever in U.S. Anned Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRANSPORTATION UNKNOWN other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be treent of Health and Menta tant: If itam 27 is marked jury or other traumatic evines. ပ UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3811 HILLSDALE RD. Date SISTER-BALTIMORE, ROSE CUNNINGHAM IN-LAW 20b. Place of Disposition (Name of cometery, crematory or other place) MD 21207 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or once. ARBUSTUS MEM PK 9/20/04 BALTIMORE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service License 4600 LIBERTY HGHTS AV, BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Mentils Immediate Cause (Final Pnysician metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of: Examine cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown <u>۾</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No P 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After tha Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospice 50 32. Rec 31. Date filed (Month, Day, Year) Registrar

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		Í	1 - For State Registrar	Olato ol ma	., (0.114 / 2	•	ificate of		.,	, ,	g. No.	O I	00761
			1. Decedent's Name (First, Middle, Last)						2	. Date of Death Month		Year	3. Time of Death
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			Sunrise 5. Social Security Number 6. Sex	7 Age	(In yrs. last bir	thday)	Pi If Under 1 Year	kesvil		Date of Birth		timor	
н	Funeral Director		218-03-5454	M 2XF			Months Days	Hours	Min.	Month, Day, une 17,	1919	Chi	lace (State or Foreign try)
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	arylar show	ž	10a. State 10b. County		10c. City, Tow							1	0d. Inside City Limits 1 ☐ Yes 21 No
	the M	Directo	Maryland Baltimon	re	Ann	esli	e 10f. Zip Code			10	g. Citizen of	What Cour	
	3a or	<u>-</u>	524 Anneslie Road				Ton Zip Godo	21212		.0		S.A.	
	death	Funeral		12. Was Decedent E Armed Forces?	ver in U.S.	13. Wa	as Decedent of I es, specify Cub			ly Yes or No-	14. Ra	ce - Americ	
õ	or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 X N	0		Tes, specify Cub ☐ Yes 2 🂢 No		, Fuello Nic	ball, etc.)		ack, White, ify: Chin	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show imatic event, if a Medical Examiner most be notified at	ed by	3 X Widowed 4 □ Divorced	Year or Dates:	162								
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פ	al Hy f other	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Nam <i>e (F</i>	First, Middle, Ma	aiden Suma	me)	
Za	should but Ment marked	To	Yick You Lee					Lucy					
<u>a</u>	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type Eric Lee			-	Address (Street						
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ב פ	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Ro 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			<i>tory or other pla</i> Park Cen		9-2				Maryland
Baltimore,	# 문문분		21. Signature of Funeral Service License	99	LOTTO								
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п			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused to cause on each line	the death. Do r	not enter	the mode of dyir	ng, such as c	cardiac or r	espiratory arres	t,		Approximate Interval Between
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	/Medical Examiner		resulting in dealing	Due to (or as a	consequence	of):	1. R	neart	CA				
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or d	w require been sig should t					_				1 🗆 Yes	2∕□No	3 Prob	ably 4 Unknown
Records,	e law i has b	Completed								24a. Was an autopsy		prior to con	osy findings available apletion of cause of
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0	<u> </u>	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day	28b. T	Time of njury	28c. Injur	ry at		5 Residen  1. Describe how			)
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Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	ırm, stree	t, factory, office		28f	Location (Stre City or Town,		ber or Rura	Route Number,
	pital ours a seral Derail		29a. Certifier Certifying Phys	ician: To the best of	my knowledge	dogth o	agured at the ti	mo data and	I place and	f due to the cou	=-(=) == d ==		
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director; Aft completely filled in by the fun	edical	(Check only one)	ner: On the basis of and manner stat	examination and	d/or inves	stigation, in my o	ppinion, death	h occurred	at the time, date	e and place,	anner as so and due to	the cause(s)
	within To th compl	Me	29b. Signature and title of certifier	11	. /	-	29c. Licens	se number	<i>i</i>	290	I. Date signe	ed (Month, L	Day, Year)
	. 1		11/m	Nul	1/1	7.1	)	0321	6391		6	7/17	104
	50		30. Name and address of person who co		A				001	_		_	
			Timothy Herlihy, 1 31. Date filed (Month, Day, Year)	M.D. 120		Pie	rre Dr.	Suite	204	Towson	, Mary	yland	21204
	Sta Registr		SEP 2 0 2004	Benefic	6	Soc	als						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician ANN LEWIS 10: eptember 17 2004 BEVERLY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None NUrsinG BALTINORE MANGE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) SEPT 26, 1958 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-87-8803 1 M 2 F mary Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be nutified at es 2 No BAITH HUKE Directo Morey Lowo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US12 2/2 50 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HABC Security ick grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fi f Health and Mental H frem 27 is marked oth other traumatic even Ellew Hinton JUHN LOWIS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If Item 27 I 3600 BALLMER Mary / mo Cv. 6/1/82 Lowis 1 MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel 12 Surial 2 ☐ Cremation 3 ☐ Removal from State 9/25/04 ZIEN BALHHUEL 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHNIMA - 11 my i'm wall 21. Signature of Funeral Service Licensee BALTING MIL DALL 23a. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sta **Physician** RNd disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** 340 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown detach signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 BUnknown been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 240 No page 2 autopsy performed? certificate 1 Yes 28 No director 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 : After this funeral c 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: or Attending 1 XNatural 5 Pending investigation after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and fifte of certifier 30. Name and address of person who completed callse of death (Item 23a) (Type, Print) Och Raun Blud 353 LHOU 6 AL 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Box

P.O.

Records,

of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 5:37M September 16, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SALTIMORE CITY Under 1 Year If Under 24 Hrs. 8. Dr JOHNS HOPKINS HOSPITAL 5. Social Security Number If Unde Months 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2∏F Min. 38 212-94-7010 **Director** Oct. 1965 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exertiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1620 Trawler Lane USA Funeral <u> 21401</u> 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2**X N**o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) 12 College (1-4or 5+) Hygiene. Senior Health Care Analyst Health Care 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 ts marked oth Forrest Edwin England Dorothy Rosemary Lien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lavis (Husband) 1620 Trawler Lane, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or \* 4 ☐ Donation 5 ☐ Other (Specify) 9-20-2004 Metro Crematory Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hardesty Funeral Home, P.A 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory
Due to (or as a consequence of): **Physician** Failure 12 hours /Medical **Examiner** Melanoma Mctastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 Yes 2 No 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number Tracy f. Wanner, Medical Doctor 29d. Date signed (Month, Day, Year) RES - 000 September 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tracy Wanner, The Johns Hopkins Hospital, Tower 10, 600 NORTH WOIFE STILET, BALTIMORE, MD 21287
31. Date filed (Month, Day, Year)
32. Segistrar's Signature State SEP 2 0 2004

Registrar

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registra <b>AMEND TIEM</b>		-	partment of F <b>estiticate of</b>		, ,	ene g.No.∩∩.	20051.
	Dhusisi		1. Decedent's Name (First, Middle, L	ast)	1111	<i>3033 71211</i>	2.	. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Miriam		1.	Leda			r 15, 200	4  4:00 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, gi				Location of Death		4c. County of De	
			Future Care 5. Social Security Number 6.	J	l e (In yrs. last birthd		sterstown	. Date of Birth	Balti	
L	Funeral Director		220-14-9064 Usual Residence of Decedent	1 M 2 🔀 F	86 Yrs	Months Days	Hours Min. S	ept 21,	1917	irthplace (State or Foreign Country) PA
	land ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary	tor	MD Balt	imore		Owings 1	Mills			1 ☐ Yes 2 🙀 No
	h the	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	23a c	al D	11 Bradbury Ro	ad		2	1117		U.S.A	•
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other then "natural; or items 23s or 28s-f show other traumatic event, the Medical Examinations to in	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Ever in U.S. 1	<ol> <li>Was Decedent of H   If Yes, specify Cuba   1 ☐ Yes 2 No</li> </ol>	ispanic Origin? (Specif in, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	2 hou	ted	15. Decedent's I	Education	16a. De	cedent's Usual Occup	ation during most of working	1	6b. Kind of Busines	s/Industry
215	thin 7	npie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	i+)	e. DO NOT use retired	i)			
21	filed wi Hygien sther th	Con	10		H	lomemaker	40.11.4.11.4.11		Own I	lome
and	be fill	Be	17. Father's Name (First, Middle, Las	(1)			18. Mother's Name (F			
Ž	should be and Mental amarkad o umatic eva	은	George Victor  19a. Informant's Name/Relationship		19b M	ailing Address (Street	Adolpn and Number or Rural R	ina Vis		Zin Code)
Maryland	id 2 should be Ith and Mental 27 Is markad o traumatic eve				7209		Way, Balti			<i></i>
ē,	s 1 ar I Hea Item 2		Miriam Cholewczyr 20a. Method of Disposition			sposition (Name of crematory or other place			Oc. Location - City of	r Town, State
Baltimore,	9 = 5 0 = 5		1 ☐ Burial 2 🖾 Cremation 3  `4 ☐ Donation 5 ☐ Other (Spec				Ser 9/16/	04 I	Hampstead	, Maryland
a E	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Lice		1/-		ss of Facility 1182			
Ä	permi Depa Impo any it		Stephen	M. Je	ubers !					ryland 21136
	Physician /Medical Examiner		23a. Part1. Enter he disease, or coshock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	aDue to (or as	MASSI a consequence of):	VE STROKE	HYPERTENS		st,	Approximate Interval Between Onset and Death
68760,	rificate be executed ing physician and a as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. LOS	S OF CONS a consequence of):	CIOUSNESS				
P.O. Box 6	that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of do Month	elivery Day Year
	s that ned b	by Pr	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
rds	w requires that s been signed E should be deta	ed b	flatros 1	81.410	FAILU	RE TO THRI	VE.	1 ☐ Yes	2 1 MG 3 □ F	Probably 4 Unknown
Vital Records,	The la ate has page 2	Completed						24a. Was an autopsy performe	ed? prior to death?	utopsy findings available completion of cause of s
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Hospital		0.1	26. Place of Death (C			
of\	S S	70	1 Yes 2 No	Hospital:			4 deursing Home		ice 6 Other (Sp.	ecity)
n	ng fter ne	Certification:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending  2 ☐ Accident investigati	28a. Date of Inju (Month, Da	y Year) 200. Time	y Wor	yat 200 k? Yes 2 □ No	I. Describe flow	v injury occurred	
Division	Attanding or death. actor: After by the fune	ficat	3 Suicide 6 Could not	be One Diese of Ini	ury - At home, farm,	street, factory, office		. Location (Stre	eet and Number or F	Rural Route Number,
Ď	after Dira	ertii	4  Homicide determine	building, et	c. (Specify)			City or Town,		
	To the Hospital or Attandii within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	ledical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	Physician: To the best aminer: On the basis of and manner sta	f examination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, and pinion, death occurred	d due to the cau at the time, dat	use(s) and manner a re and place, and du	is stated. le to the cause(s)
	To the within Fo the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Mor	nth, Day, Year)
	. 21-0		- Mall P	Vicey	Mue	101	4123		7/16	104
	9		30. Name and address of person wh	completed cause of d	eath (Item 23a) (Ty	pe, Print)	Kessi	1/2,1	Main	Sand
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 0 20	- D	ar's Signature	rede			*	21133

Amend item # 17, per FH, C835, 19/29/04 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Yeer Sycuester SEPTEMBER 16 2004 MEIkn 13:52 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES HEALTH BALTIMORE, MD

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) SAINT CARE BALT IMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**≥**M 2□ F 218 40 79 62 YES Director 63 EB14, 1941 mmy Usual Residence of Decedent with the Maryland 10a. State 10b County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo BAI HILLE 1 os 2 No mary kno 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? N. Riggers 2/2/1 4514 U SA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. nit. Pages 1 and 2 should be filed within 72 hours after a rannent of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural, or itei inlury or other traumatic event, the Medical Expuring. Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Ş 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Franka StorE 12th gode 17. Father's Name (First, Middle, Last) OCYUISON 18. Mother's Name (First, Middle, Maiden Surname) Secretary George Lee BAILOY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7411. Fulkn 158/1 (JertrupE) Bot house, Med 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Sremation 3 Removal from State permit. Page Department of Important; If any injury or 22. Name and Address of Facility 4 Donation 5 Other (Specify) OYERN HOUSE Baltrurk 21. Signature of Funeral Service Licenses TOAN - NOWIT FOOD HAL SE 40 Ressection Hari Bal AMER, 23a. Part1. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician SEPTIC SHOCK disease or condition resulting in death) 48 HOURS /Medical Due to (or as a consequence of): Examiner ACUTE RENAL FAILURE 48 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Unusitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit CIRRHOSIS OF THE LIVER YEARS Due to (or as a consequence of): attending physician for use as the burial Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DIABETES MELLITUS 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy performed' certificate Vital 1 Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No o this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After Certification: 28d. Describe how injury occurred Division Hospital or Attending Injury 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident Director: in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 T Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DONNA BILU, MD P18607 SEPTEMBER 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAINT AGNES HEALTHCARE 900 BALTIMORE, MD 21229 CATON AVENUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			Decedent's Name (First, Middle, Last)	·	imouto or boat	2. Dete of De		3. Time of Death
	Physici /Medi		Jessie Lo	is Logo	21	Month O 9	Dey Yeer	9:35PM
):	Examir		4a Fecility Name (If not institution, give street end nu		. 0.	Town, or Location of Dear	th 4c. County of Death	
				EEN CENTE		CIMORE der 24 Hrs. 8. Date of Bi		100
	Funeral Director		5. Sociel Security Number  214 · 16 · 5432  Usuel Residence of Decedent	7. Age (In yrs. last birthday) Yrs.	Months Days Hour		A, 1913 VIR	place (State or Foreign intry) GINIA
	lend		10a. State 10b. County	10c. City, Town or Loca	ation			10d. Insigle City Limits
	a-f sh	ctor	MD	BAUTIN	nort			Yes 2 □ No
	h with the 23a or 28	Funeral Director	2700 KEYWORTH	AVE.	10f. Zin Code	215	10g. Citizen of What Cou	intry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mentel Hygiene. Depertment of Health and Mentel Hygiene important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Dec Armed For I Yes If Yes, Girl Yes or D	2 1 No /e 1 [	as Decedent of Hispanic Yes, specify Caban, Mexi	Origin? (Specify Yes or Nocan, Puerto Rican, etc.)	o- 14. Race - Ameri Black, White Specify:	
21215-0020	72 ho natur	Completed by	15. Decedent's Education (Specify only highest grede completed)	16e. Decede	ent's Usual Occupation ind of work done during m Q_NOT use retired)	nost of working	16b. Kind of Business/Ir	
121	within ene.	g	Elementary/Secondary (0-12) College		O NOT use retired) B <b>E</b> AUTICIAI		HATR	
	filed withi Hygiene. other than		17. Fether's Neme (First, Middle, Lest)			other's Name (First, Middle		
Maryland	Mentel	To Be	CHARLES WILS			MADLE.		
	1 and 2 shot Health and em 27 is mo other traum		19a. Informant's Name/Relationship (Type, Print)  CATHERINE M. SMITH	ANUTION 4807	ALHAM	BLA AVE.	BACT, MORE	MD 21212
Baltimore,	Pages 1 nent of He nt: If Iten		20a. Method of Disposition 1 ☐ Burial 2 D Cremation 3 ☐ Removal from	State	atory or other place)	Date Date	20c. Location - City or T	
Ë	permit. Pag Depertment Important: I any Injury o	724	4 Donation 5 Other (Specify)	GREENMOUN		DRY 7.11.01	BACTIMOLE, C. GREENE	MARYLAND
Bal	permit. Depertrimports any Inj.		21. Signature of Funeral Service Licensee	22.1	Name and Address of Fa			
	_		23a. Part1. Enter the disease, or/complications that of shock, or heart failure. List only one cause on each of the complex of the cause of the caus	aused the death. Do not enter	the mode of dving, such		MORE, MARY	Approximate
1	Physician		shock, or heart failure. List only one cause on e	ach line.			‡ 1	Interval Between Onset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition	Den	rentia			
	LAGIIIIICI	<u>-</u> 6	resulting in death)	Due to (or as a conseque				
	uted 3 ansit	Examiner	<b>₽</b> b	Due to (or as a conseque	VH		-	
ó	icate be executed physician end s the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Athero	1			
68760,	ate be hysici he bu	edicai	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):			
	ertifica ding p	Me	d.	Drabes	les M	ellitus		U
Вох	attand for us	by Physician/M						
P.O.	the d	hysi	Part II. Other significant conditions contributing to de	ath but not resulting in the und		40	tobacco use contribute t	o the cause of death? bably 4 ☐ Unknown
S,	s that gned t	y P	HAID, BAD,	Decubita	7 MGG		20110 00110	Sabiy 4 di ominemi
Division of Vital Records,	The law requires that the deeth certificate be exect ate has been signed by the attanding physician enc page 2 should be datached for usa as the burial-tr	Completed				24a. Was	ormed? av	ere autopsy findings railable prior to empletion of cause
Rec	he law e has t age 2 s	ршо				10		deeth?  ☐ Yes 2 ☑ No
ita	an: Tificat tificat tor, pa	Be	25. Was case referred to medical		26. Pla	ace of Death (Check only	Ĩ	163 212
<b>^</b>	Physician: r this certific ral diractor,	70	examiner? 1 Yes 2 No Hospital: 1 1	npatient 2 ER/Outpatient	3□ DOA Other: 4□	Nursing Home 5 ☐ Resi	dence 6 Other (Specia	(y)
Ē	ng Pt fter th unera			of Injury 28b. Time of Injury Injury	28c. Injury at Work?		how injury occurred	
isio	or Attending after death. Director: After in by tha fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	of Injury - At home, farm, stree	M 1 Yes 2		Street and Number or Run	al Route Number
Ď.	after after Direct din by	Certification:	4 Homicide determined 28e. Piece buildi	ng, etc. (Specify)	st, factory, office		wn, State)	arriodie ridinoci,
	To the Hospital or Attending Physician: The law requires that the deeth certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completaly filled in by the funeral director, page 2 should be datached for use as	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the bar one) 2 Medical Examiner: On the bar ond mani-	best of my knowledge, death our investigation and/or investigation and/o	occurred at the time, date stigation, in my opinion, d	end place, and due to the death occurred et the time,	cause(s) and manner as s date and place, and due to	stated. the cause(s)
	Fo the within Fo the	M	29b. Signature and title of certifier		29c. License numbe	ər	29d. Date signed (Month,	Day, Year)
			> 11 Ml mol	- MM	000	60539	09-17-	200 L
	3	1	30. Name end address of person who completed caus	e of deeth (Item 23a) (Type, Pr	Δ	0 11 -		MD 21201
	-		Vijay R. Hegde, MD		utaw St.	, Soute 31	08, Balli	move 1
	Sta Registr	_	31. Dave filed Worth, Day, Year) 32. R SEP 2 0 2004	egistraes Signeture	South .			<i>'</i>

DHMH 16 Rev 6/95

		1- State of Maryland / Department of Health a factor of Health a grant factor of Health a	nd Menta	l Hygie Reg.	ne No A A L	20087
Physici /Medi		1. Decedent's Name (First, Middle, Last) Vanessa Garvey Milburn	2. Dat Mo Set		Day Year 2, 2004	0652 A M
Examir		4a. Facility Name (If not institution, give street and number)  Sheppard Pratt Hospital  4b. City, Town, or Location of Towson			4c. County of Dea Balti	
Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	Min. 8. Dat Min. (Mo	e of Birth nth, Day, Ye	9. Bin Co , 1969 E	thplace (State or Foreign buntry) England
ith the Maryland or 28e-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A  10c. City, Town or Location  Baltimore				10d. Inside City Limits  M☐ Yes 2 ☐ No
n with the 3s or 28e	<b>Funeral Director</b>	10a. Street and Number 3507 Devonshire Drive 10f. Zip Code 21215			Citizen of What Co JSA	puntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant. Ite Medical English and enge.	þ	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes ★□ No  If Yes, Give Year or Dates:  1 □ Yes 2 ☒ No Specify:	in? (Specify Ye Puerto Rican, e	s or No- etc.)	14. Race - Ame Black, Whit Specify: B]	e, etc.
21215-0036 bd within 72 hours all gliene. ar than "natural", or ar than "natural", or it in Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  The elementary/Secondary (0-12)	of working		Kind of Business	Industry  Save
land and land land land land land land l	To Be C		rs Name (First, nette			
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	-	19a. Informant's Name/Relationship (Type, Print)  Janette Garvey/ Mother  19b. Mailing Address (Street and Number 3507 Devonshire)	or Rural Route Dr. B	Number, Cit altin	ty or Town, State, 2	Zip Code) 2121 aryland
Saltimore, emit. Pages 1 ar Department of Heal Department of Heal Department: If item in y injury or other once.		`4 □ Donation 5 □ Other (Specify)		4 Woo	·	Maryland
Balt permit. Departi		21. Signature of Funeral Service Lynsee 22. Name and Address of Facility 5240 Reisters	Chatm town R	an-Ha d Bal	arris Fu Ltimore,	neral Hom Md 21215
Physician		23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as consoler, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Dilated Cardiomyopathy	cardiac or respir	atory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner	Ĺ	Due to (or as a consequence of):				
68760, ficate be executed physician and the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown			23d. Date of del Month	ivery Day Year
rds, P.O. I	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	230		co use contribute to	the cause of death?
I Record The law requirate has been single page 2 should	Completed		-   .	a. Was an autopsy performed Yes 2	?   death?	ntopsy findings available completion of cause of
Division of Vital Records, P.O. Box 6 or Attanding Physician: The law requires that the death certifular death.  Diractor: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	To Be	examiner?	28d. De	Residence	6	cify)
in the second	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Street or Town, St	and Number or Ru ate)	ıral Route Number,
a Hospital 24 hours a 5 unaral E	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due occurred at the	to the cause e time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
To tha To tha To tha Complete	Me	29b. Signature and title of certifier  29c. License number  OCME			Date signed (Monti	
18,00mg		e and address of person who completed cause of death (Item 23a) (Type, Print)  TATRICANTONICA—FOLIAK NO 111 Penn St.	Ral	4 1	41. "	201
Sta Regist		31. Date filed (Month, Day, Year) 32. Filigistrar's Signature 32. Filigistrar's Signature	Car			•

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 11:10 PM Physician SEPT 2004 4a. Facylity Name (If not institution, give street and number) HIDDLETON /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 6. Sex 7. As BAI HALLE E

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 113 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months .**≱**□M 2□F Director 66-4694 MARGIANO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. and if flem 27 is marked other than "natural", or Items 23e or 28a-f show ury or rother treumatic event, Ite Musical Examines must be neithered. 1 Tes 2 No Balhmore MAKYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 9 S. BELNICE USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1. Dustry Private 10 H grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MAYbell MaTH15 2 JOSHUA Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maybell Middleton S. BERNICL AVE Baltimer, Maryone MUTHER 01209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20 Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Iron Cometer 9-18-04 BATHWEE Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CNATHING - HALLIS FURIS KINGE 21. Signature of Funeral Service Livensee 25a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. 52 40 Raisteristown Rd Boltines Marylone 31215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4□Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 QUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No this certificate 1 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100140 (Uch Raver Blvd, Ballmine, VWD 21239) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month SEP) 32. B State Registrar

	,	1 - For State Registrar	State of Maryland / D	Department of Health and Certificate of Death	d Mental Hygie	
Physicia /Medic		1. Decedent's Name (First, Middle, La	FRANCES	MCCONNELL	2. Date of Death Month SEPTEM B	Day Year 3. Time of Death ER 17 2004 12.50 PM
Examine	er ·	4a. Facility Name (If not institution, gines of the property o	re street and number) HOSPITAL Sex 7. Age (In yrs. last birti	4b. City, Town, or Location of De  BALTINOR t  If Under 1 Year   If Under 24 H	=	4c. County of Death n/a
Funeral Director			TH OFF	rs. Months Days Hours M		9. Birthplace (State or Foreign Country) RI
uth with the Maryland 23e or 28e-1 show ust be millied at	ctor	10a. State 10b. County  MD Anne A	rundel Glen	or Location Burnie		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with th	Dire	10e. Street and Number	3	10f. Zip Code	10g.	. Citizen of What Country?
urs aftar des ai', or items Xamiliatin	by Funeral Director	6660 Shelly R  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	21061  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: White
n 72	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of v life. DO NOT use retired)	rorking 16i	b. Kind of Business/Industry
be filed withintal Hygiena. Id othar than	Con	9 17. Father's Name (First, Middle, Last		Waitress	ame (Cient Middle Mai	Restraurant
should be filed and Mental Hygi markad othar matic evant, I	To Be	John_Kelly		Li11	ame (First, Middle, Mai .ian Foley	7
1 and 2 s Health ar Sm 27 is Thar trau		19a. Informant's Name/Relationship ( Vicki Robertso 20a. Method of Disposition 1 □ Burial 2 *** Cremation 3 □	n/Daughter 41  Removal from State 20b. Place of cemetery	Mailing Address (Street and Number or 6 West Court Gipposition (Name of community or other place)	len Burni Date 200	Le, MD 21061 c. Location - City or Town, State
permit. Pages Department of I Important: If its any injury or o		'4 □Donation 5 □Other (Special Service Lice)  21. Signature of Funeral Service Lice	- Day vi		.J.Gonce	Baltimore, MD Funeral Home, PA adena, MD 21122
ficate be physicials to the but	ledicai Examiner	shock, or near failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in the same immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the death. Do not one cause on each line.  a	SEPSIS ENCEPHAL		Interval Between Onset and Death 2 WEEK
the death certificate y the attending phys sched for use as the	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
es ti	þ	Part II. Other significant conditions of	contributing to death but not resulting in		23e. Did tobaco	co use contribute to the cause of death? 2 □ No 3 万 Probably 4 □ Unknown
The lay	Completed	MYDCARDII	HL INFARCTI	ON.	24a. Was an autopsy performed 1 Yes 2.	
sicia cer rect	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital: 1 ☑Inpatient 2 ☐ ER/Outp		eath Check only one)	
Jing Aftar fune	ation: To	27. Manner of Death  1 KNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tir	natient 3 DOA 4 Nursing The of 28c. Injury at Work?  M 1 Yes 2 No	Home 5 Residence 28d. Describe how in	o 6 ∐Other (Specify) njury occurred
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Hospi 4 hou Funer ely fill	Medical	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example	ysician: To the best of my knowledge, niner: On the basis of examination and and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	e, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
To the To the Complete	<b>S</b>	29b. Signature and title of certifier	PMD	29c. License number RES 00	1	Date signed (Month, Day, Year)  PTEMBER 17 200
Stat	e	30. Name and address of person who AN A DC - PA 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (T K HARBOR HOC) 32. Registrar's Signature	ype, Print)		RSTREET, BALTIMUL MD 21225

	thony M -05877	ar		e Type or Prin	t in Black	ludelibie lui	ko Ensure A	All Copies	Are Legibl	9.
cn	ח		1 - For Stata Registrar	e Type or Prin lend 1 tem # State of Ma	ryland / De	partment of ertificate of	Health and I Theath		211111	29660
			Decedent's Name (First, Middle, I	.ast)		0.10010 0.	Douili	2. Date of Dear	ag. No. 🔾 🔾 🥎 h	3. Time of Death
н	Physic		Anthony March	.Ir				Month	Day Ye	ar M
	/Medi Examiı		4a. Facility Name (If not institution, g			4b. City, Town,	or Location of Deatl	Septemb	er 12, 2	004 1:46 A M
1			Prince George'	s Hospital	Center	Cheve				George's
	Funeral			Sex 7. Age	(In yrs. last birthda		r If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		218-08-8991	1 <b>⋈</b> M 2□F	19 Yrs.	. Months Days	TIOUTS WIIII.	02 0		MD
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryi f sho	ō								1√ Yes 2 No
	1 the	Director	10e. Street and Number		Baltimo	10f. Zip Code		1	0g. Citizen of Wha	
	3a or		4833 Wilern Av	0		212	15			
	death	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S. 1		Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No-		merican Indian,
9	or Ite	F	Never Married 2☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give	0			o Rican, etc.)		/hite, etc.
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:		1□ Yes XXNo	э эрөспу.		Specify:	Black
21215-0036	id 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It is marked other then "neturel", or Items 23a or 28e-f show treumetic event, the Medical Experiment must be notified at	Completed	15. Decedent's (Specify only highest of		16a. De	cedent's Usual Occu ive kind of work done	upation e during most of wor ed)	king	16b. Kind of Busine	ess/Industry
12	within ene.	mc.	Elementary/Secondary (0-12)	College (1-4or 5-	+)		<i>өа)</i>			
	filed within Hygiene.	Be C	11th grade 17. Father's Name (First, Middle, La.	na		Student	18. Mother's Nam	ne (First, Middle, M	Schoo. Maiden Sumame)	<u> </u>
Maryland	ould be Mental warked o	To B	Anthony March	Sr.				L Hudson	,	
ary	2 should the and Menter is marked eumatic	-	19a. Informant's Name/Relationship		19b. Ma	ailing Address (Stree	at and Number or Ru			e, Zip Code)
	1 and 2 Health a em 27 is		Kendall Jones	-Mother	4833	3 Wilern	Ave, Ba	altimore	bM .e	21215
ore	of Healt fitem 2		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla			20c. Location - City	
Ĕ	Pages ment of I ent: If ite ury or o		1 ∑Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		Mt. Zio	on Cemet	ery 9/18	3/04	Baltimo	ce. Md
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Lic	ensee /		22. Name and Add				
_	707 e d		Flugn	1726		4300 Wab	ash Ave	Baltin	nore, Mo	21215
			23a. Par 1. Enter the disease, or co shock, or heart falure. List on	mplications that caused to one cause on each line	the death. Do not e	enter the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition resulting in death)	a Multy	le gua	shot W.	march			Onset and Death
	/Medical Examiner			Due to (or as a	consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
	ecuted and -transit	amine	Cause (Disease or injury							
Ć.		Еха	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					
68760,	ficate be exe physician ar s the burial-t			d.						
99	rtifica ng ph as th	Medi	IEEE.WE							
Box	death certificate be ex e attending physician e d for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		B⊟Ectopic pregnanc	ev.		23d. Date of	,
O.	ie dea the at hed fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown		Other (specify)			Month	Day Year
<u>o</u> .	a of		Part II. Other significant conditions	contributing to dooth but	not roculting in the		Landa Banki	CO. Division		
ds,	signed of be det	1 by	raitii. Other significant conditions	contributing to death but	not resulting in the	underlying cause gr	ven in Part I.			to the cause of death?
000	law requires as been sign 2 should be	etec						1 1 10	3 2 □ No 3 □	Probably 4 Unknown
Records,	9 4	Completed						24a. Was an autopsy	prior	autopsy findings available o completion of cause of
-	ician: The l certificate ha rector, page	_						1 Yes 2	ed? death □ No 1 1 2 Y	? es 2□No
Vital	Physician: this certific ral director,	) Be	25. Was case referred to medical exeminer?  1 ☐ Yes 2 ☐ No	Hospital:	ER/Outpati	O#	ha-	h (Check only one		
of	r Phy or this oral d	٦. ا	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury	28b. Time		4   Nursing Ho	ome 5 Resider 28d. Describe how	nce 6 Other (S	pecify)
Division	Attending or death. sector: After by the fune	ţ	1 □Natural 5 □ Pending 2 □ Accident investigation	on (Month, Day		Wo	rk? Yes 2 No	Soulsit	c/	
Visi	Attendigent death.  Betor: A  By the fu	Hice	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injur	y - At home, farm,	street, factory, office	^	1	et and Number or	Rural Route Number,
	s afte	Certification:	- Varionicido	building, etc.	(Specify)	lich		City or Town,	State) 2 40	Rural Route Number,
	To the Hospitel or Attending Physician: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying P	hysician: To the best of	my knowledge, de	ath occurred at the ti	me, date and place,	and due to the car	use(s) and manner	as stated.
	the H nin 24 the F tplete	ledicai		miner: On the basis of e and manner state	ed.	investigation, in my o	opinion, death occur	red at the time, dat	e and place, and d	ue to the cause(s)
	To To	Σ	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mo	nth, Day, Year)

29d. Date signed (Month, Day, Year) September 12, 2004

completed cause of leath (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

3 State Registrar

THEOPORE M.
31. Date filed (Month, Day, Year)

32. Pogistrar's Signature

SEP 2 0 2004

		State of Maryland / Department of Health and	Mental Hygiene
		Certificate of Death	Reg/No O
ı	Physician /Medical		2. Dete of Death Dey Year September 16, 2004 1:00AM
	Examiner	4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or	Location of Death 4c. County of Death
		Saint Joseph Nursing Home Catonsvi	
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs 21.4 _ 03 _ 23.66	(Month, Day, Yeer) Country)
	Director	214-03-2366 1 M 2X P 97 Yrs. Usuel Residence of Decedent	08/01/1907 Maryland
	land	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	the Marylan 28a-f show notified at	Maryland Baltimore Catonsville	1 ☐ Yes 2 ☐ No
	fter death with the Ma r ttems 23a or 23a-fs Thet must be notifies Funeral Directol	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
	3a or	1222 Tugwell Drive 21228	United States
	daati	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (See See See See See See See See See Se	
21215-0036	urs a	If Yes, Give 1 Yes Qive 1 Yes Specify:	Specify: White
2-0	led within 72 hours lygiene. The Medical Exit, the Medical Exit.	15. Decedent's Education 16e. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of wo	16b. Kind of Business/Industry
2	within than the	Elementary/Secondary (0-12) College (1-4or 5+)	
21	Hygien ther the	8 Clerk	Pharmaceutical
<u>n</u>	lental Hygi ked other ilc event,	17. Father's Neme (First, Middle, Last)	me (First, Middle, Maiden Surname)
چ	should by and Menta marked imatic eventuals.	tarry se	urel Route Number, City or Town, State, Zip Code)
Maryland	s 1 and 2 should be filed if Haalth and Mental Hyg Item 27 is marked othe other traumatic event, To Be C		ace Columbia, Maryland 21044
	Haal Haal em 2 other	20a Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
ē	ages ant of it: If it y or c	XX Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  XX Burial 2 □ Cremation 3 □ Removal from State 5 Cometery, crematory or other place)  St. Stanislaus Cemetery	9/18/04 Baltimore, Maryland
Baltimore,	permit. Pages 1 an Department of Haai important: If Item 2 any injury or other pnce.		vid J. Weber Funeral Homes PA
ä	S S E S S	5311 Edmondson Ave	nue Baltimore, Maryland 21229
		23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	
	Physician		Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  e. Mount at The Author Due to (or as a consequence of):	2hrs
	ē l	resulting in death)  Due to (or as a consequence of):	
oʻ.	icata ba axecuted physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	
68760,	icata ba physicie s the bui	C. Due to (or as e consequence of):  To a consequence of the consequen	
Box	in or it		
o.	0 0 0	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
σ.	raquiras that tha dei een signed by the a hould be datached f		1 Yes 2 201 No 3 Probably 4 Unknown
rds	v raquiras been sig should b		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
Records,	aw 2 s b		completion of cause of death?
ĕ	The law sata has page 2		1
of Vital	ysician: The is certificata director, pag		ath (Check only one)
Š	S D	1 ☐ Yes 2 ♣ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ® Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
	frer thi uneral		28d. Describe how injury occurred
Sio	Attending or death. ector: Afte by the fune	2 Accident investigation  2 Accident investigation  3 Suicide 6 Could not be called no	28f. Location (Street and Number or Rural Route Number.
Division	after Directif ertif	determined determined building, etc. (Specify)	City or Town, State)
_	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completaly filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place (Check only one)  Check only one)  Check only one)	
	within 2 To the comple		29d. Date signed (Month, Day, Year)
	F \$ F 0	1 Edmu 18 (1 Kunnt 1 D34951	9-16-2004
	18	30 Name end eddress of person who completed cause of death (Item 29a) (Type, Print)	
	1.		Cornorllares 21228
	State Registrar	0. And 17 homes	

DHMH 16 Rev 6/95

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 615 AM Month Year **Physician** Matilda M. Ostrowski Deptember 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Nursing Home Harford litizens Havre If Under 1 Year 8. Date of Birth 11/10/1914 5, Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours 1 ☐ M 258 F Mary Land 218-10-8563 89 Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Harford Jarrettsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 Twin Lakes Drive 21084 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: ۵ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Assembly Weapons Manufacture permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If item 27 is marked other tt any injury or other traumatic event, If ite once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Smith Genevieve Karis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Urbanski- Niece 2000 Twin Lakes Drive Harford, Maryland 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 109/20/2004 Baltimore, Maryland 21. Signature of Funeral Service Licenses David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician alnutulion /Medical Due to (or as a consequence of): **Examiner** boune Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of The law requires that the death certificate be executed burial-transit emenles attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 1 ☐ Yes 2 No the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No Certification; To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Willhour 9-17.04 1)32-600 b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kammidin Mithauses 110e R Havre De Grace

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

SEP 2 0 2004

Ustrowski, Matilda

32. Registrar's Signature

Amend item # 19a,26, per FH, Phy (835, 9/20/04 TI)

For Amend Item 2 per Dr., 12/09/04 and Mental Hygiene

1- State Registrar

Certificate of Docth 2. Date of Death 09/15/2004 3. Time of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** EVELYN 5:20 AM 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 752 N. GRAN N BALTIMORE STREET TLEY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 ☐ M 2 😿 F MD 25.12.3126 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show rel', or Items 23a or 28a-f shov Examiner must be nutified at MD 1 Yes 2 No BALTIMORE Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atler and of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel, or Ite any or other teaumatic event, Ite Medical Examins any 1 Never Married 2 Married BLACK Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAR CLEANER WESTERN MD RAILROAD 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM H. LITTL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TIG N. ROSEDALE ST. BALTO, MD 21216 William H. Lane/ Son Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If eny injury or once. NOODLAWN, MD WOODL 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES 5151 BALTIMURE NATIL PIKE BALTO. MD 212291 21. Signature of Funeral Service Lice 669 ano 23a. Part1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE Dementia 7/2 **Physician** disease or condition resulting in death) /Medical Examiner ENSID-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury anemia I-transit The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) Ö the 9 Unknown 9 Unknown signed by I Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Scular 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s autopsy performed? mmob; 1 Yes 2 No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 2 1 Inpatient 2 ER/Outpatient 3□ DOA 5 X Residence 6 € Street (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury Natural 5 Pending To the Funeral Director: Aft To the Funeral Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 10 2004 son who completed cause of death \_\_\_m 23a) (Type, Print) 4805 Benson A Baltimore, MD MO Kerl/4

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

			1- For State of Maryland / Department / Department / Department / Department / Department / Depa	artment of Health and Menta	al Hygiene Reg. No. 004 29664
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last)  VIRGINIA W. PROUDFOOT  4a. Facility Name (If not institution, give street and number)	Mo	te of Death onth Day Year  EMBER 16.2004 12:15AM  4c. County of Death
-	Funeral	eı	Saint Joseph Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs. 8. Dar Months   Days   Hours   Min. (Mr.	Baltimore  te of Birth onth, Day, Year)  9. Birthplace (State or Foreign Country)
	Director		235-30-4577		5/1915 WEST VIRGINIA  10d. Inside City Limits
	ter death with the Marylar itams 23a or 28a-f ehow iter must be notified at	Director	MD BALTIMORE PARKY	10f. Zip Code	1 ☐ Yes 2 📉 No
036	urs af	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 □ Wo	21234  Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:	USA ss or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify:  WHTTE
21215-0036	d within jiene. r than '	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12TH GRADE  (Give life.)  College (1-4or 5+)  EXEC	dent's Usual Occupation kind of work done during most of working DO NOT use retired) UTTIVE SECRETARY	16b. Kind of Business/Industry BENDIX
Maryland	o d a b	To Be	17. Father's Name (First, Middle, Last)  GEORGE WILSON  19a. Informant's Name/Relationship (Type, Print)  19b. Mailli	18. Mother's Name (First,  LILLY PHILE  ng Address (Street and Number or Rural Route	
d)	l and 2 s fealth ar im 27 io har trau		ROBERT SCHUMANN/SON-IN-LAW 3304  20a. Method of Disposition 20b. Place of Disposition completely contained to the second state of the second state	ACTON ROAD BALTIMORE	
Baltimore,	permit. Pages I Department of H Important: If its any injury or ot		*4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	MEM. PARK 9/18/200	OHNSON FUNERAL HOME, P.A.
68760,	Friysician /Medical Examiner	dical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		ratory arrest, Approximate Interval Between Onset and Death
P.O. Box (	es that the death certificat igned by the attending phy be detached for use as th	Physician/Med		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
Records,	v requir been s should	Completed by	Part II. Other significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing to death but not resulting in the ununity transfer of the significant conditions contributing the significant conditions conditions contributed to the significant conditions c	24	e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown  a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes 2 No
ion of Vital	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	atlon; To Be	25. Was case referred to medical examiner?  1		k only one)  ☐ Residence 6 ☐ Other (Specify)  scribe how injury occurred
Division	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	City	ation (Street and Number or Rural Route Number, or Town, State)
	To the Hospital within 24 hours a To the Funaral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death (Check only one)  1 Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, and due vestigation, in my opinion, death occurred at the 29c. License number	to the cause(s) and manner as stated.  e time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
<b>)</b>	13+8		30. Name and addr ss o erson who completed cause of death (Item 23a) (Type.	D 4141@	Sellember 17th, 2014
	Sta Registr	11	31. Date filed (Month, Day, Year)  SEP 2. 0 2004	SLER DRIVE TOWSON	MARYLAND 21204

hysicia		Decedent's Name (First, Middle, Las.	")				2. Date of Dea Month SEPT •		o\d{4}	3. Time of 0952	Death A M	
ledica amine	al -	James 4a. Facility Name (If not institution, give	street and number)	P	artin, J	r Location of Death	OLIT 1	4c. County		0932	AW	
ne		329 MAGOTHY BLV	<b>)</b> .		PASADE				ARUN	NDEL		
		5. Social Security Number  6. Security Number  6. Security Number  10  11  12  13  14  15  15  15  16  16  16  16  16  17  17  18  18  18  18  18  18  18  18	7. Age (In yrs. 45	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Nov. 1	th y, Year) 6,1958	9. Birthp Cour Mary	place (State on try) land	r Foreign	
		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	IOd. Inside Ci	,	
	Funeral Director	Maryland Anne Ar	undel Pas	sadena	100			40.00		1 🗆 Yes	2 🖺 No	
		10e. Street and Number			10f. Zip Code	0		10g. Citizen of		ntry?		
	nera	329 Magothy Blvd.  11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of h	Z Hispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-	U.S - 14. Rac		can Indian,		
L	by Fu	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 Ma No If Yes, Give Year or Dates:		1☐Yes 2█No		, , ,	Specif	y			
-	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of B	Whi usiness/In			
	Completed	(Specify only highest grad	College (1-4or 5+)			during most of workind)	19	TT.	D.1	1. 0	,	
(	S	12 17. Father's Name (First, Middle, Last)	N/A	Ma	ster Plu	mber 18. Mother's Name	(First, Middle.	Target		bing C	ю.	
	To Be	James A	. I	Partin,	Sr.	Florence		м.		ner		
		19a. Informant's Name/Relationship (7				and Number or Rura		er, City or Town,	State, Zip	Code)		
	-	Florence M. Parti	20b. I	Place of Dispo	lagothy B	D	ena, M	aryland 20c. Location				
		1 ■ Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, crer	natory`or other pla	ce)					1	
	1	21. Signature of Funeral Service Licens	OTC	22	n Mem. P	ass of Facility		Glen Bu		Maryl	and .	
		23a. Parl. Enter the disease, or comp	Ellins		04 Mount	lyniak Fur ain Road F	asadena	a, Mary	land_	21122		
1	dicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to (or as a consect bDue to (or as a consect cDue to (or as a consect d	quence of):	AKDIOVAS	COLAR DISE	19315					
	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 pronths?  1 ☐ Yas 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								23d. Date of delivery Month Day Year		
	ğ	Part II. Other significant conditions of	entributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use cont		ne cause of di ably 4 🗀 U		
9	Completed						1 Seres	rmed? 2 \( \text{No} \)	prior to coi death?	psy findings ampletion of ca	available ause of	
1	ertification; To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju	4   Naising Hon	ie 5□Resid			) AT S	CENE	
	ertifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		eet, factory, office	2	8f. Location (S City or Tow	Street and Numb un, State)	er or Rura	i Route Numi	ber,	
- 1	O	29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, death	n occurred at the ti	me, date and place, a	nd due to the d d at the time, d	cause(s) and ma	anner as st	ated. the cause(s)	)	
1	Medicai C	(Check only one)  25 Medical Examone)  29b. Signature and title of pertifier	iner: On the basis of examina and manner stated.	ation and/or in	29c. Licens			29d. Date signe			1	

			1 - For State Registrar		ryland / De	epartment of Certificate of	Health and N	Mental Hyg	iene	29666
	Physici	ian	Decedent's Name (First, Middle,	· ·	A	. 1		2. Date of Deat Month		3. Time of Death
	/Medic				OSYA			Sept 1	5,2004	15:54 PM
	Examir	ner	4a. Facility Name (If not institution, the Howard County Ge		-al	4b. City, Town, Columb	or Location of Death		4c. County of Death	
4-5	Funeral	-			(In yrs. last birtho			8. Date of Birth	Howard	place (State or Foreign
	Director		652-16-6384 Usual Residence of Decedent	1□M 2√F 58		Months Days		(Month, Day, Nov. 19,	1945 Arme	place (State or Foreign ntry) BIII a
	hours after death with the Maryland tural; or ttems 23a or 28e-f show all Fractional for redified at	-	10a. State 10b. County	1	10c. City, Town o	r Location				10d. Inside City Limits
	86-13	Director	MD Howard	i	Columb					1 ∏Yes 2 ☐ No XX
	ours after death with the Marylan ral", or Items 23a or 28e-f show Examinat must be modified at	Ē	10e. Street and Number 10306 HICkory Ri	dao Doad 4	222	10f. Zip Code			og. Citizen of What Cou	ntry?
	leath ns 23	Funeral	11. Marital Status	12. Was Decedent Ev	322	21044	Hispanic Origin? /So		Armenia  14. Race - Americ	nan Indian
٥	or Her	Fu	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No		<ol> <li>Was Decedent of If Yes, specify Cub</li> </ol>		Rican, etc.)	Black, White,	
2-003e	iral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: Wh	nite
<u> </u>	22	Completed	15. Decedent's (Specify only highest		16a. De	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of work	ring	6b. Kind of Business/In	dustry
7	within ene.	dm	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +			<b>∌d</b> )		_	
7 0	filed Hygi ther		17. Father's Name (First, Middle, La		50.	ientist	18. Mother's Name		Government	Contracting
<u>a</u> a	id be ental ked c	To Be	Bagrat Petrosyar	1				(unknown	•	
ary	s 1 and 2 should f Health and Men item 27 ie marke other treumetic.	-	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (Stree	-		City or Town, State, Zip	Code)
Σ.	and 2 salth an 27 in 27 in er tre		Ashot Hovanesian			7 Creeksid		Vienna,	VA 22182	
e e	es 1 ar of Hea if item rr othe		20a. Method of Disposition 1 Deliberation 3	Removal from State	20b. Place of Discemetery, of	sposition (Name of crematory or other pla	ice)	Date 2	0c. Location - City or To	wn, State
Ĕ	mit. Pages bertment of i cortent: If it injury or o	Н	'4 □ Donation 5 □ Other (Spe	Li terriovar ironi otate		undel Crem	1	/2004	Odenton, Ma	ryland
эаппшог	permit. Deperti Importa any nji		21. Signature of Funeral Service Lic	ensee		Bonaldson	Funeral	Home, P.	Α.	
	20 ≥ € Ø		23a. Part1. Enter the disease, of co	M007		313 Talbo	tt Avenue	Laurel	, Maryland	20707
,00	Physician /Medical Examiner  who private transit	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Motor ve Due to (or as a c	consequence of):	iuma - rib f fibria fra ccident	Practures, (Foss	s femur, ible aorti	© Hbula	Onset and Death
.O. BOX 0	Attening Physicien: The law requires that the death certificate be executed to death certificate be executed and death. After this certificate has been signed by the attending physician and by the funeral director, page 2 s ould be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Qther (specify) 9 ☐ Unknown						23d. Date of delive Month	ry Day Year
-	s that ned b e deta	by Pł	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
ž	w require been sig s ould b	edt						1 ☐ Yes	2 Proba	ably 4 Unknown
וומכר	2 2 2	Completed						24a. Was an autopsy performs	prior to con death?	osy findings available inpletion of cause of
	cian: ertific ector,	Be (	25. Was case referred to medical exampler?				26. Place of Death		3.10	
5	Physic this c	은	1 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpat	ient 3□ DOA Oth	er: 4 Nursing Hor	ne 5 Residen	ce 6 ☐Other (Specify	)
	ing F After funera	Certifica Ion:	27. Manner of Death 1 □ N tural 5 □ Pending	28a. Date of Injury (Month, Day Yo		y Wor	k?	28d. Describe how	injury occurred oss double ye	ilouline
2	deat deat ctor: / the	ica	2 Maccident investigation 3 ☐ Suicide 6 ☐ Could not	be 390 Place of Laive			Yes 2 Lano	- hit onco	ming car hes	id on
2	for A after Direction by	ertif	4 Homicide determine	building, etc. (	Specify)			City or Town,		MO
	To the Hospitel or Attenting Physician: The within 24 hours after deatl.  To the Funeral Director: After his certificate h completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying F	Physician: To the best of maminer: On the basis of examiner and manner stated	ny knowledge, de amination and/or	ath occurred at the tir	ne date and place a	and due to the cau	se(s) and manner as state and place, and due to	tod
	Fo the within Fo the comple	Me	29b. Signature and tyle of certifier	T T	) O.T.	29c. Licens	e number	290	I. Date signed (Month, D	Pay, Year)
	4		1 Jofan A.	IND	MAZ	72	1473		Sept 16.	
	10		30. Name and address of person who	completed cause of deat	h (Item 23a) (Typ					
	\		PATRICE A. TOTE	MD 4565 +	TEMLOC	K LONE h	int, Euro	نحد درتم	MO ZIC	:42
	Star Registra		31. Date filed (Month, Day, Year) SEP 2 0 2004	32. Registrar's		Sparks		-		

			1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygier	2001 20000			
1. Decedent's Name (First, Middle, Last) 2. Da							3. Time of Death			
	/Medi		SISTER M. JE	ANETTE PITSINGER, MH	SH	Septembe	er 16, 2004 9:30 A <sup>M</sup>			
	Exami		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or Location of Deal		4c. County of Death			
			THE VILLA		Rodgers Forge	9	Baltimore County			
	Funeral		Social Security Number     6. S	TM 257E	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	9 Birtholace (State or Foreign			
	Director		215-07-8550 Usuel Residence of Decedent	92 Yrs.		Mar 3, 19				
	land		10a. State 10b. County	10c. City, Town or Lo	cation	,	10d. Inside City Limits			
	be filed within 72 hours after death with the Maryland hat Hygiene. Id Hygiene. Id other than "nature!", or items 23a or 28a-f ahow avent, it a Medical Examinar must be indiffed at	Funeral Director	Maryland Baltimor		gers Forge	102	1 ☐ Yes 2 ☐ No			
	3a or	0	6806 Bellona Ave	2012		109.1	Citizen of What Country?			
	death ms 2	era	11. Marital Status		Vas Decedent of Hispanic Origin? (S	nacity Voc or No	USA 14. Race - American Indian,			
g	or Ite	Ē	1 Never Married 2 Married	Armed Forces?	Vas Decedent of Hispanic Origin? (S I Yes, specify Cuban, Mexican, Puerl	o Rican, etc.)	Black, White, etc.			
Ö	el'.	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:	Yes 2 No Specify:		Specify: White			
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		ent's Usual Occupation	16b.	Kind of Business/Industry			
2	thin e	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of wor OO NOT use retired)	Ch.	nristian			
2	ed w	Co		/.	un		Ministry			
nd	tal H	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nar	ne (First, Middle, Maide	en Sumame)			
yla	Men Men arke	ုင	Joseph Edward P		Margai	et Ann Hay	res			
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Itsm 27 is marked other than other traumatic event, ILA Max		19a. Informant's Name/Relationship (7	(T • IV • )	g Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)			
	5 = 12 T		Sr. Judith Waldt,	MHSH 1001	W. Joppa Road, 1	Towson. Mar	yland 21204			
Baltimore,	of Hea of Hea if itsm		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	200. Place of Dispos	sition (Name of atory or other place)	Date 20c.	ocation - City or Town, State			
Ë	permit. Pages Department of I Important: If Its any injury or o		* 4 ☐Donation 5 ☐ Other (Specify	New Cathe		/20/2004 19	altimore, Maryland			
att	permit. Departminity imports any inju		21. Signatura / Funcial Survey Lives	22	Name and Address of Facility	7 207 200H L	ittimbre, arytano			
<u>m</u>	20 = 2 9		Martin D. La	wson	itchell-Wiedefeld	Funeral H	ome, Inc.			
			22. Name and Address of Facility  Martin D. Lewson  22. Name and Address of Facility  Mitchell-Wiedefeld Funeral Home, Inc.  6500 York Road, Baltimore, Maryland  Approximate shock, or heart failure. List only one cause on each line.  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bern Inte							
	Physician		Immediate Cause (Final disease or condition	Oneumon	1		Onset and Death			
	/Medical		resulting in death)	a Due to (or as a consequence of):	beart faile		1 week			
	Examiner			(menting	los + 0= 0.		10 YV			
	S	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	faile	ma .	- 7			
	outed ansil	Examiner		C						
ó	exe en ar rial-tı		resulting in death) Last	Due to (or as a consequence of):						
8760,	death certificate be executed eattending physicien and of for use as the burial-transit	dlcal	(	d						
9	tifica ig ph as th	led								
Вох	leath certific attending p	7	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery			
	deat e att	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5☐	Ectopic pregnancy Other (specify)		Month Day Year			
P.O.	t the by th tache	hys	9 Unknown	9□ Unknown						
	The law requires that the de- ate has been signed by the a bage 2 should be detached fo	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?			
Ö	w require been sig should b					1 ☐ Yes 2	Probably 4 ☐Unknown			
00	s bee	Completed				24a. Was an				
Re	he lav e has age 2:	mc				autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
a		Ö	25. Was case referred to medical			1 ☐ Yes 2 ☑ No				
>	Attending Physiclan: The I r death. sector: After this certificate ha by the funeral director, page	00	examiner?	Hospital:		h (Check only one)				
of	Phy orthic	. To	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatient  28a. Date of Injury 28b. Time of	all son a little sing no	me 5 Residence	6 □Other (Specify)			
Division of Vital Records,	Afte tune	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ny occurred			
<u>s</u>	l or Attendi after death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, stree		206				
<u>S</u> .	after Dire	ert	4 Homicide determined	building, etc. (Specify)	it, ractory, office	City or Town, State	nd Number or Rural Route Number, e)			
	apita ours nerel filled	0	29a. Certifier 1 Certifying Phy	mician: To the best of mulicavidades death						
	To the Hospital or Attent within 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exemi	sician: To the best of my knowledge, death oner: On the basis of examination and/or inve- and manner stated.	stigation, in my opinion, death occurr	and due to the cause(s ed at the time, date and	) and manner as stated.  d place, and due to the cause(s)			
	o thin o thin o mpl	Me	29b. Signature and title of certifier	and married stateog.	29c License number	004 D	Andrew delta del			
•	r>+0		1 mia	- B Kree m	031045	25G. Da	1 ( / / /			
	3	-			77/80	7	11014			
	U			ompleted cause of death (Item 23a) (Type, Pr	821 N Guita	and of the state	Bactimore ma			
	Sta	0	Mien Kioune, M. I 31. Date filed (Month, Day, Year)	32. Registrar's Signature	or po	~ I reet	und there ma			
	State State		SEP 2 0 2004	here &	/ /		21201			

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

	7		Certificate of Death	,	giene Reg. No.	04	29668
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Joseph A. Robinson	2. Date of Dea	Day	Year 2004	3. Time of Death 2145
	Exami	ner	4a. Fecility Name (IT not institution, give street and number)  4b. City, Town, or Li	ocation of Death		of Death	
	Funeral Director		5. Social Security Number 238-42-0406  6. Sex XX M 2 F 7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birt (Month, Day Aug • 24	h y, Year)	9. Birthplac Country North	e (State or Foreign Carolina
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d.	Inside City Limits
	e Man	cto	MD Anne Arundel Severn				1 □ Yes 2 No
	ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number         10f. Zip Code           1828 Blue Jay Court         21144		10g. Citizen of V US	_	?
020	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. It has the marked other than "natural", or itams 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at	5	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto Year or Dates: Vietnam	ecify Yes or No- Rican, etc.)	14. Race Blace Specify	e - American k, White, etc	
21215-0020	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ring	16b. Kind of Bu	ısiness/Indus	try
121	filed wi Hygien offher tha		12 Master Sergeant		U.S. A		-
Maryland	should be fi and Mental H s marked of umatic eval	To Be	17. Father's Name (First, Middle, Last)  Archibald B. Robinson  Sallie (		Maiden Sumam	e)	
ary	2 shou and M is marl aumati	۲	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run		r, City or Town,	State, Zip Co	de)
	1 and 2 Health em 27 i		Sherri Robinson (Daughter) 451 Bergen St., Apt. 11  20a. Method of Disposition (Name of				
nor	Peges nent of h nt: If ite		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	9 <b>-26</b> 2004	Crownsv		
Baltimore,	permit. Peges 1 and Department of Health Important: If Item 27 any Injury or other tr once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral I	Home, P.A	١.		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	_			proximate
, a	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Acute Cardine Arrhy  esulting in death)			Int	erval Between set and Death
	P #	lner	Due to (or as a consequence of):  Out of the conditions  Due to (or as a consequence of):  Due to (or as a consequence of):				
	cate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury c.		*****	1	
68760,	te be e ysiciar ne buri		trial initiated events		- 1-90		
	entifica ing ph e as th	Medical	resulting in death) Last  d.				
Box	eath cer attendir I for use	clan					
P.O.	res that the de signed by the s be detached	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			tribute to the 3  Probabl	cause of deeth?
	res tha signed I be de	by	Hyperlipidemia	\			
of Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed		24a. Was a perform	n autopsy ned?	availab	utopsy findings le prior to tion of cause h?
alF			OF Was associated to market	1 □ Ye	7	1 □ Ye	s 2 No
Ž	Physician: r this certific rial director,	To Be	25. Was case referred to medical examiner?  1			r (Specify)	
	ding Ph h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Unjury at Work? 28c. Injury at Work?	28d. Describe ho			
Division	or Attending atter death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 4 Homicide	28f. Location (St. City or Town		r or Rural Ro	ute Number,
_	Hospital Hospital Hours Funeral tely filled	edical Ce	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a common control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca ed at the time, da	ause(s) and man ate and place, ar	ner as stated and due to the	cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier  Deput 4  29c. License number	-cf 25	d. Date signed	(Month, Day,	Year)
			Millian of fish mo Dollas	•	9/10	4/4	
	10		30. Name and address of person who completed dayse of death (Item 23a) (Type, Print)  Aliliam P. Jones, mD 695 Ame	rich	210	35	
	Sta Registr		29b. Signature and title of certifier  29b. Signature and difference of death (Item 23a) (Type, Print)  30. Name and address of person who completed states of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature				

			For State Registrar		epartment of H	ealth and Mental Hygic	ene 1.No.2004 29669
1	2		1. Decedent's Name (First, Middle, Last	")		2. Date of Death	3. Time of Death
	Physici /Medio		JEAN	Ruminski		September	- 18 204 12:10 am
7	Examir		4e. Facility Name (If not institution, give	street and number)	4b. City, Town, or	Location of Death	4c. County of Deeth
				reral Hospital	Balting	ye City	
at ,	Funeral Director	V I	220 20 3211	744 0045 275	rs. If Under 1 Year Months Days	Hours Min. 8. Date of Birth (Month, Day, )	(ear) 1926  9. Birthplace (State or Foreign Country) MARY And
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		
	the Marylar 28e-f ehow	Director	Maryland Baltim		Dundalk		10d. Inside City Limits 1
	th with the 23a or 2	ai Dire	1826 Marshal	1 Road	10f. Zip Code	222	United States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f ehow importent: If item 27 is marked other than "natural", or items 23e or 28e-f ehow any injury or other traumatic event, the Modical Examinar maralize ricitlish and ance.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1  Yes 2 No	spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.)  Specify:	14. Race - American Indian, Black, White, etc. Specify: While
5-0	natur	eted	15. Decedent's Edu (Specify only highest grad	ication 16a. (	Decedent's Usual Occupa	ition 16	6b. Kind of Business/Industry
21215-0036	2 should be filed within and Mental Hygiene. is marked other than " aumatic event, the Mex	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done d life. DO NOT use retired)	uning most of working	Food Berrice
	be filed tal Hygie of other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Ma	niden Sumame)
ylaı	should b	To	Carmelo	Ruminski		Emma	GIArdina
Maryland	12 sh h and 7 is m rraum		19a. Informant's Name/Relationship (T)	1 1		nd Number or Rural Route Number, (	
	1 and Health em 27		GINA KUMINSKI  20a. Method of Disposition		824 Marsh Disposition (Name of		DC. Location - City or Town, State
nor	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	, crematory or other place	September 22	
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens		22. Name and Address	s of Facility	Baltimore Maryland
m	Depa Impo		~~~~~	X	Connelly Fu	meral Home of IV	ndalk, P.A. MD. 21222
	Physician /Medical Examiner	/Medical resulting in death)  Due to (or as a consequence of):					
8760,	cate be executed oblysician and the burial-transit	lical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of	);		
O. Box 6	the death certifi by the attending pached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Records, P.	quires tha n signed I uld be det	Ď	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause give		cco use contribute to the cause of death?  2 □ No 3 □ Probably 4 ℚVinknown
000	aw requir is been si 2 should I	piete				24a. Was an	24b. Were autopsy findings available
al Re	10	Completed				autopsy performe 1 ☐ Yes 2 [	prior to completion of cause of
of Vital	Physician: this certificant	Be	25. Was case referred to medical examiner?	tospital:	0	26. Place of Death (Check only one)	
	Phys r this ral di	: To	1 Yes 2 No	1 Lightnpatient 2 Liet/Outp		4 Nursing Home 5 Hesidend	
ion	Attending I r death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation		ury Work'	es 2 \( \text{No} \)	injury occurred
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time for investigation, in my opi	e, date and place, and due to the caus inion, death occurred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier		29c. License	number 29d	. Date signed (Month, Day, Year)
)			Rulty RANG	AMATHAN MADHAU	m.D. 895		9-18-04
	$\wedge$		30. Name and address of person who co	ompleted cause of death (Item 23a) (T	ype, Print)		100 TO 10
	1		Ranganathan madi	navan m.D. 40 M	laryland C	reneral Hospita	2
	Sta Registr		31. Date filed (Month, Day, Year) SFP 2. 0. 2004	32. Registrar's Signature	Sports		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician ROSENZWEIG MORRIS SEPTEMBER 14, 4:15A 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth SEPT. 18, 1919 Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex **Funeral** Months Days Hours Min 1 **∑**M 2 □ F MD 84 Yrs 219-32-1579 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County st than "natural, or items 23s or 28s-f show the Medical Examinar must be nutitied at 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21209 6806 OLD PIMLICO ROAD o filed within 72 hours after death vil Hygiene. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **MERCHANT** CLOTHING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event SIDE. Be **ISRAEL** ROSENZWEIG IDA ABRAHAM ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6806 OLD PIMLICO ROAD - BALTIMORE, MD 21209 SHIRLEY ROSENZWEIG / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State (ANSHE EMUNAH)AITZ CHAIM 9/15/04 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service L 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CLEAR CELL CARCINOMA OF MEDIASTINUM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No 24a. Was an autopsy 22 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1X Inpatient 2 ER/Outpatient 3 DOA PIS 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; After Hospital or Attending 24 hours after death. 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4104 D 37254 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIM M.D. 7601 OSLER DRIVE TOWSON MARYLAND 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2 0 2004

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registra Reg. No. UUL Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2350 LIGENE 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 9/13/1930 5. Social Security Number 216–28–5913 9. Birthplace (State or Foreign **Funeral** M 2□ F Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at MD Harford WHITEFORD 1 Yes X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 4110 McNabb Road 21160 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 TYYes 2 No If Yes, Given 950-53 Year or Data 950-53 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ KNo Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Automotive Repair Mechanic 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Wilburn Ashton Ross Maude Nora Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: If Item 27 is any injury or other trau once. Opal R. Ross/Wife 4110 McNabb Road, Whiteford, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Broad Creek Friends Cemetery 9/15/2004 Street, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CEREBROVARCULAR **Physician** disease or condition resulting in death) -1721 /Medical Due to (or as a consequence of): Examiner THERORC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CELL ANSITIONAL 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown

has certificate or Attending Physician: this

Director: After that in by the funeral

Completed Be ို Certification; 29a. Certifier

24a. Was an autopsy performed 1 Yes 21 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

MYASTH ENIA 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Mann of Death

2 Accident

3 ☐ Suicide

4 Homicide

Hospital: 
▶☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

ENINGEOMA

2 PER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D41080 29d. Date signed (Month, Day, Year)

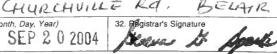
9/13/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1208, Rd.

Md. 21014

State Registrar

31. Date filed (Month, Day, Year) SEP 2 0 2004



To the Funeral

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Medical

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	Physicia		CLARENCE	Roy		5eptember	16. 2004	820 A M
	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number) EL NH	4b. City, Town, or Location of Death		Ic. County of Death	
	Funeral Director	4	5. Social Security Number 6. Sex	7. Age (In yrs. last birthda) 2□ F Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthple Count Mary La	ace (State or Foreign nd
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10	d. Inside City Limits
	Maryli f sho	ō	MD NA	Ba	altimore			Yes 2□No
	r 28a-	Director	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Count	ry?
	h with	aiD	6518 Eberle Drive Apt	202	21215		USA	
036	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show od other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be inclified at	by Funeral	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sinf Yes, specify Cuban, Mexican, Puerto     □ Yes 2 X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e Specify: Black	
5-0036	72 hor	ted	15. Decedent's Educat (Specify only highest grade c	ompleted) (Gir	cedent's Usual Occupation ve kind of work done during most of work		Kind of Business/Ind	ustry
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	led w lygier her th		9 17. Father's Name (First, Middle, Last)	unknown	Custodial  18 Mother's Nan	ne (First, Middle, Maid		
anc	0 a b >	Be	17. Fallier's Haille [First, Middle, East)	UIRTIOWII	Ruth Jon			
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	2	19a. Informant's Name/Relationship (Type)	Print) 19b. Ma	tilling Address (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip	Code)
S	and 2 sealth arm 27 is		Lucy A. Roy / Wife	65	18 Eberle Drive Apt 202	Baltimore,M	21215	
ē,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)	Date 20c.	Location - City or Tov	vn, State
Ë	Pages nent of int: If it		1 Parial 2 □ Cremation 3 □ Rem 1 □ Donation 5 □ Other (Specify)		ge Cemetery 9-21-	-04 Ba	ltimore, MD	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumattic 90cs.		21. Signature of Funeral Service Licensee	_	22. Name and Address of Facility Wylie Funeral Home 638	N. Gilmor St	. Baltimore,	MD 21217
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Dur to (or as a consequence of):	FARCT DS	mente	4	
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	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5875				
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687	ifficate g phy as the	Physician/Medical						
Вох	death certific e attending p id for use as i	In/M	23b. Was decedent pregnant	. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of deliver	y Day Year
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n of			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injur	y Work?	28d. Describe how in	njury occurred	
sio	Attending Ir death. actor: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	20 - Diago of Injury Al home form	M 1 Yes 2 No	28f Location (Street	and Number or Rural	Route Number
Division	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, St	ate)	, robio rumbo,
<b>—</b>	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying Physic	cian: To the best of my knowledge, de	eath occurred at the time, date and place	e, and due to the cause	e(s) and manner as st	ated.
	Pe Hoo	ledicai	(Check only 2) Medical Examine	r: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occu	urred at the time, date	and place, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of pentition	matin	29c. License number	29d.	Date signed (Month,	Day, Year)
			MCNEALBRO	CKINGTON MD	13240	4 4	16-4	
	4	(	30. Name (no) addless of person who com	pleted cause of death (Item 23h) (Ty	RO4 BILAO	Ma.	21215	
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 0 2004	32 Registrar's Signature	barke			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 09 Rheubottom 2004 Lucille 1:30a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6713 Alter Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 M X F Director 87 218-18-3478 04 28 MD Usual Residence of Decedent with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventines must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1XYes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 6713 Alter Street Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: Completed by 3 ₩Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Surgical Assistant Private Office 2yrs 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nellie Payne ဂ Arthur Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alter Street, Baltimore 21207 Valerie Gregory-Daughter 6713 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Metro Crematory Inc. 9/17/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OVEL YEO /Medical Due to (or as a consequence of): **Examiner** Moi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death), act Physician/Medical Examiner Due to (or as a consequence of): the death certificate be executed the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown been signad by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has certificate 1 ☐ Yes 2 10 No lai or Attending Physician: T s after death. al Diractor: After this certificat ed in by the funeral director, ps 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes Other: 4 Nursing Home 2 2 NO 2 ER/Outpatient 3□ DOA 5 Residence 6 Dother (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours aft To tha Funaral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature nd title of certifie 29c. License number 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) 30. Name and address 31. Date filed (Month, Day, Year) State Registrar SEP 2 0 2004

			1 - State Registrar	State of	Marylar		artment of I rtificate of			•	giene Reg. No. 1	and the state of t	29671
	Physici	an	1. Decedent's Name (First, Middle, Last	)						2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic	al	PHOENCIE				41. Oh. T.	.1		leptom		2004	4:46 PM
	Examin	er	4a. Facility Name (If not institution, give  MERCY HOSPICE	street and num	iber)		4b. City, Town, o		or Death		4c. County	of Death	
	Funeral		5. Social Security Number 6. Se		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under		8. Date of Birt	h	9. Birthp	lace (State or Foreign
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Z B	id 2 si Ith an 27 is r traur		Eunice U. Smith/D				g Address (Street N. Fulto						,
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altimore,	Page nent o int: #		1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from S	late		natory or other pla		09-1	7-04	BALTIMO	RE, N	MARYLAND
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importance if I fleam 27 is marked other than "natural", or items 23a or 28e-1 ahow any injury or other traumatic event. It is Marical Exacting than the natified at once.		21. Signature of Funery Bervice Licens	99		W:	Name and Addre	BROWN	COM				
	-		28a. Part1. Enter the disease, or complished, or heart failure. List only o	ications that ca	used the deat					respiratory ar	rest,		Approximate Interval Between
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ó	an and rial-tra	Exa	resulting in death) Last	Due to (o	ras a conseq	uence of):					7		
58760,	icate be executed physician and s the burial-transit	dical	(	d									
_			IF FEMALE:	22a Historia auto									
Box	The law requires that the death certif te has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months?		ome or pregna th 2 ☐ Feta nt at time of d	Ideath 3	Ectopic pregnancy Other (specify)	1			23d. Dat Mor	te of delive: nth	ry Day Year
o.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov		16a(ii 5 _	Other (specify) _						
ري م	res that igned b be deta	by Pt	Part II. Other significent conditions co	ntributing to dea	ath but not res	ulting in the ur	derlying cause giv	en in Part I.		23e. Did to	bacco use contr	ribute to th	e cause of death?
rds	en sig									1 □ Y	es 20 No	3 🗌 Proba	ably 4 ∐Unknown
Records,	law requias been 2 should	piet								24a. Was a	an 24b. V	Vere autop	sy findings available
_		Completed								perfor	med?	leath?	
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<u></u>	Phys r this ral dii	- 10	1 Yes 2 No	1 ☐ In		ER/Outpatient		4 🗆 Nur		e 5 Resid	ence 6 Othe	er (Specify	nospice
0	nding P th. : After I e funera	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	Injury	28c. Injur Wor M 1	k? Yes 2□N			ow injury cocurs	00	•
N N	l or Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o	of Injury - At ho	ome, farm, stre	eet, factory, office		28	3f. Location (S. City or Tow	treet and Number	er or Aural	Route Number,
ā	ital or irs afte ral Dir led in												
	To the Hospital or Attending Physician: within 24 hours after dealt within 24 hours after dealt with this certific completely filled in by the funeral director, completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 2 Medicel Exami	sician: To the bas ner: On the bas and manne	sis of examina	wledge, death tion and/or inv	occurred at the tirestigation, in my o	ne, date and pinion, deati	d place, ar h occurred	nd due to the c d at the time, d	ause(s) and mai late and place, a	nner as sta and due to	ated. the cause(s)
	othe	Med	29b. Signature and title of certifier	And marine	or stated.		29c. Licens	e number		2	29d. Date signed	i (Month, E	Pay, Year)
	-> = 0		by.	(hu)	~		14	0850	11			3/20	
	N		30-Name and address of person who co	empleted cause	of death (Item	n 23a) (Type, I	Print)	000					
				elera	30	157	PCUL	PL.	Bal	Limo	re m	d.	20212
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 20	N.	istrar's Signa	iture							

Registrar
DHMH 17 Rev 1/2001

SEP 2 0 2004

Registrar
DHMH 17 Rev 1/2001

State

MD 111 Penn Street, Baltimore, Maryland 21201

Kollok

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASONICA

ALV.

SEP 2 0 2004

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SAMUEL 2004 WST. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PARKVILLE BALTIMORE OAK CREST | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 1/2 4/1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MARYLAND 6. Sex **Funeral** 213-12-2984 1 □ M 2 🔀 F 89 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 28e-f shov treumatic event. The Madical Examiner must be notified at 1 ☐ Yes 2 XNo Director BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 WALTHER BLVD. 21234 USA Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) 10YRS College (1-4or 5+) HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 99 HENRY SCHNEIDER ANNA BORKMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trei once JANET PLUM (DAUGHTER) 11 BELLMAN CT. KINGSVILLE, MD. 21087. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 09/16/2004 BALTO.CITY, MD `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cecabial Vascular Disecs & disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Itypertensio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day 4☐Pregnant at time of death 5 Other (specify) Ö ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 ☐ Yes 2 ▼ No this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending 1 Natural death. investigation 1 Yes 2 No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Fur erel D completely (illed) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

Registrar DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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SEP 2 0 2004

Grade

Boulewas

32 Registrar's Signature

anc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

as

1756646

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mon

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #19a&b &20a&b PERC FEH FC CRESS OF 1204 TH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month AND ALEXANDER reptember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rei Hane N If Under 1 Year If Under 24 Hrs. are 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) DUNE 28,1931 **Funeral** 9. Birthplace (State or Foreign Days Hours 150 M 2 F 224-34-0744 Director IRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or itema 23s or 28s-f show traumatic event, the Madical Extratriating trains the notified at 1XYes 2 ☐ No Directo MARVLAND 뱌 10g. Citizen of What Country? 10e. Street and Number 80 NORTH AVENUE USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 May Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: BLACK 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "ray liury or other traumatic event, Its Med once. College (1-4or 5+) Elementary/Secondary (0-12) 12+HGRADE ABORER SHIPVARD 17. Father's Name (First, Middle, Last) じんはいのじん 18. Mother's Name (First, Middle, Maiden Sumame) じんにいらいいん 19a. Informant's Name/Relationship (Type, Print) CORA E WILLIAMS 2 c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date WilborneBaptist Church Waverly, Virginia 1 ⊠Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN. 21. Signature of Funeral Service Licensee JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atheroscleratic Vascular Disease disease or condition resulting in death) C GY S /Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events the attending physician and hed for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Vital 1 ☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 4 hours after death unaral Diractor: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D5 8 un Enposi

Registrar
DHMH 17 Rev 1/2001

ORIGINAL

Avenue Baltimore Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Esposito

31. Date filed (Month, Day, Year)

900 Caton

32. Registrar's Signature

				partment of Health and Me	1	
			1 - Stete Registrar	ertificate of Death	Reg. N	2001. 20070
Н	Physici		1. Decedent's Name (First, Middle, Last)  LUCILLE  TERRY		2. Date of Death  Month	ay Yeer 3. Time of Death 230 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ISACTIMORE  av) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	N A 9. Birthplace (State or Foreign
	Funeral Director		25.30.0406 1 M 2 G F 6 Yrs  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10-12-19	34 Country) MD
	ryland how		10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	the Ma	Director	MD NA BALTIM		10- 6	1 <b>P</b> Yes 2 No
	3e or 3	i Dir	2921 ARLINAH AVENUE	10f. Zip Code 21216	10g. C	11SA
	ar mas 2	Funeral		Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Indian, Black, White, etc.
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel; or items 23e or 28e-f show or other treumatic event, the Medical Evaninal must be notified at	Ď	1 Never Married 2 Married 1 Yes 2 No 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BLACK
2-0	72 ho	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of working b. DO NOT use retired)	g 16b.	Kind of Business/Industry
21215-0036	filed within Hygiene. other than	Completed	Elementary/Secondary (0·12) College (1·4or 5+) HON	and the second s		OMESTIC
	ould be filed Mental Hygid arked other atic event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maide	en Sumame)
Maryland	2 should and Men is marke eumatic	2	WILLIAM BRUCE JOHNSON  19a. Informant's Name/Relationship (Type, Print)  19b. M	ailing Address (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)
	1 and 2 Health a lem 27 is		GEORGE IERRY 292		BALTO. A	10 21216
nore	Pages 1 nent of H int: If ite			sposition (Name of Parematory or other place)  PARK  00-21		Location - City or Town, State
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funçal Service Licens	22. Name and Address of Facility VAUGHN C. GREENE FU 515 BALTO NATU PIKE	INTERAL SE	
	20260		23a. Part1. Enterthe disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	515 BALTO NATU PIKE enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
Į.	Pnysician		Immediate Cause (Final disease or condition	DISEASE		Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	-		
	be is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
oʻ	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initialed events resulting in death) Last C. Due to (or as a consequence of):			
09289	cate be physicia the bu	dical	d			
ŏ	anding I use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death	3 ⊟Ectopic pregnancy		23d. Date of delivery
.O. B	the the	Physician/Med	in the past 12 months?  1  Yes 2 No 9 Unknown	5 Other (specify)		Month Day Year
٩	res that the igned by be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I.		use contribute to the cause of death?
Records,	w requir been si should	eted	Sensis Sandra		1 ☐ Yes	2 No 3 Probably 4 Junknown  24b. Were autopsy findings available
Re	The lav	Completed	24,15 3 per 11c		autopsy performed?	prior to completion of cause of death?
Vital	Phyeicien: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?	26. Place of Death		
of		n: To	27 Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at 28	e 5 Residence  Bd. Describe how inj	6 ☐Other (Specify) ury occurred
Division	를 근통 j	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Divi	el or Att s after d I Direct d in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28	8f. Location (Street and City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitei or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)  Check only one one one of the basis of examination and/o and manner stated.	eath occurred at the time, date and place, are investigation, in my opinion, death occurred	nd due to the cause( d at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To th Withir To th	M	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
	m		30. Name and address of person who completed cause of death (Item 23a) (Ty	De, Print)		CTT/70RE 170 21202
	Sta	ató			CE ISA	C1/11011E 070 61202
	Regist		31. Date files (Month, Day, Year)  SEP 2 0 200 4  SEP 2 0 200 4	Sporte		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** TAYLOR 12:00 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner APT#9 BALTIMORE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. NA BELVEDERE 8. Date of Birth (Month, Day, 10 · 27 - 1 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 219-38-3049 10 M 2□ F اما MD Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show item 27 is marked other than "naturel", or items 23a or 28a-1 shov other traumatic event, it e Medical Examinar must be notified at 1 Yes 2 No MD NIA BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2500 21215 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN BD EDUCATIONS NA 8 TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 TAYLOR A SADIE CORNISH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3035 PATRICIA ITH ST., ANDERSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or BALTO. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BAUG. NATU PIKE, BAUG. MID an 23a. Part1. Enter be isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jebere **Physician** disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physicien and I for use as the burial-transit Physician/Medicai IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page this certificate 2 🗌 No 1 ☐ Yes 2 10 No 1 Yes of Vital or Attending Physician: 25. Was case referred to nedical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only open Other: 4 ☐ Nursing Home 5 esidence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28b. Time of 8d. Describe how injury occurred Certification: Injury 1 atural 5 Pending 1 ☐ Yes 2 📆 🗡 o death. investigation 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital completely filled 29a. Certifier 🗠 certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ath (Item 23a) (Type, Print) of person 2 32. Registr 31. Date filed (Month, Day, Year) State Registrar

					partment of Health and	l Mental Hygi	iene	
			State Registrar	C	ertificate of Death	Re	g. Nd. 1 1 1	9681
	Physici	an	1. Decedent's Name (First, Middle, Last)	THANKA		2. Date of Death Month	Day Yeer	3. Time of Death
	/Media	al	MAKY	THOMAS		SEPTEMBE	200	1044 AM
7	Examir	er	4a. Facility Name (If not institution, give stre	p.ta(2300 wast boilting	4b. City, Town, or Location of De	no 1 e	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 H	rs. 8. Date of Birth	N/A	ice (State or Foreign
	Director		217-20-9171 1DM	20XF 85 Yrs	Months Days Hours Mi	n. (Month, Day, 01/06)	Year) Countr	YLAND
	pu 🛦 🖫		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	Location			
	with the Maryland a or 28e-f show be notified at	5	V	Too. Oity, Town o			10	d. Inside City Limits  147 Yes 2 No
	289-1	Director	MD N/A  10e. Street and Number		BALTIMORE C.		og. Citizen of What Count	**
	3a or		4.0.0	STREET	21216		USA	· ·
	urs after death v al', or Items 23a Everdrer must	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin?     If Yes, specify Cuban, Mexican, Pure Cuban, Pure Cu	(Specify Yes or No-	14. Race - America	
9	or Ite		1 Never Married 2 Married	1 ☐ Yes 2√ No If Yes Give	1 ☐ Yes YXNO Specify:	erto Alcan, etc.)	Black, White, et	
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or Items 23a or 28e-f show int, The Medical Examination mailing an	d by	3A Widowed 4 Divorced	Year or Dates:			. Вп	ACK
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2121	d withir giene. r then	mo		College (1-4or 5+)	HOUSEWIFE		OWN HOME	
פּ	0 = 0 \$	BeC	11 TH GRADE 17. Father's Name (First, Middle, Last)			ame (First, Middle, M		
ylaı	should be and Mental marked o	Tof	JOSHUA WILLIAM	S	MAI	BEL HAWK	KINS	
Maryland	and and surr		19a. Informant's Name/Relationship (Type,		ailing Address (Street and Number or			
	s 1 and 3 if Health item 27 other tre		WILLIAM E. THOMA  20a. Method of Disposition		809 ASHBURTON S	Date BALT	IMORE, MD	21216
δ	S = = 0		XXBuriat 2 Cremation 3 Rem	oval from State cemetery, o	crematory or other place)		0c. Location - City or Tow	n, State
altimore,	permit. Page Department of Importent: If any Injury or once.		* 4 □Donation 5 □ Other (Specify)  21. Signature of Fulley Service Licensee	ARBUT	US MEMORIAL PK 22. Name and Address of Facility			•
Ba	permit. Departr Import any Inj once.		1/Klle Och	well X2	4600 LIBERTY H	IOWELL FU	NERAL HOM	E 21207
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death. Do not ause on each line.	enter the mode of dying, such as cardi	ac or respiratory arres	st. A	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	Acute	Myocardial	Infar	/	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	/			
	- Administr	J.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	oftension			
	ted nsit	Examiner	Cause (Diseese or injury	Dae to (or as a consequence or).				
Ć,	execuin and ial-trai	Еха	that initiated events c resulting in death) Last	Due to (or as a consequence of):				
58760,	ficate be executed physician and s the burial-transit	edical	d					
89	ing ph	Med	IF FEMALE:					
Вох	leath certific attending p	ian/M	23b. Was decedent pregnant in the past 12 months?		3 Ectopic pregnancy		23d. Date of delivery Month D	ay Year
0	the a	Physic	1 Ves 2 No	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		, working b	ay rear
P.O	res that the digned by the be detached		Part II. Other significant conditions contrib	outing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to the	cause of death?
rds	quires n sign ald be	d by				1 ☐ Yes	s 2 No 3 Probab	oly 4 Zunknown
Ö	law requir as been s 2 should	Completed				24a. Was an		y findings available
Re	The la	mo				autopsy performe	ed? death?	oletion of cause of
ta	ien: artifice ctor, p	Be C	25. Was case referred to medical examiner?	Bon SCCUNT	26. Place of D	eath (Check only one,		No
>	hysic his ce Il dire	To	1 Yes 21 No	oital: 1 Inpatient 2 ER/Outpa		Home 5 ☐ Residen	nce 6 Other (Specify)	
مح Division of Vital Records,	aing Physicien:  After this certific funeral director,	ion:	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injur	y Work?	28d. Describe how	v injury occurred	
<u> </u>	death ctor: ,	Icat	Accident investigation  3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,	M 1 Yes 2 No	28f Location (Stre	eet and Number or Rural F	Pauto Alumbas
Div	after Dire	Certification:	4 Homicide determined	building, etc. (Specify)	street, factory, office	City or Town,	State)	iodie Namber,
	• Hospitel or Attending Physicien: The law requires that the death certificate burs after death. 24 hours after death. • Funerel Director: After this certificate has been signed by the attending element of the properties of the funeral director, page 2 should be detached for use a detail full of the funeral director, page 2 should be detached for use a seriely filling in by the funeral director.	salc	29a. Certifier  (Check only 2 Medical Examiner:	an: To the best of my knowledge, de	eath occurred at the time, date and place	ce, and due to the cau	use(s) and manner as state	ed.
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledical	(116)	and manner stated.	investigation, in my opinion, death occ			
	To To	Σ	29b. Signature and title of certifier	11 ( 1	29c. License number		d. Date signed (Month, Da	
	11		1/ VV /- A	Hendling Physicia	~ P00580	22 ).	eptenber 1	7 2004
	\		30. Name and address of person who comp		11 1	word by 11	and Streat	21227
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	hode	Cal Merch	11000 21-001	

## SEPTEMBER 19,2004 @ 4:30 AM Baltimore, Maryland 21215-0036 ATTHEW TAYBACK - ・ 今 Division of Vital Records, P.O. Box 68760, MAITHEW TAYBACK

		riease	State of Man		Indelible Ink.				•
	•	1 - For State Registrar	Otate of Mary		ertificate of			Jierie leg. No. 11 1	20000
		1. Decedent's Name (First, Middle, Last	t)				2. Date of Dea	ith	3. Time of Death
/sicia ledic:		MATTHEW LUT	THER TAYBAC	CK			Septemb	$er^{Day}$ 19, $200$	54 4:30A
amine	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of De	eath
eral		Gilchrist C		yrs. last birthda	TOWSO	If Under 24 Hrs.	8. Date of Birth	<u>Baltir</u>	nore sinthplace (State or Foreig
ctor		120-10-2433	X <sup>M 2□ F</sup> 85	Yrs	Months Days	Hours Min.	July 30	, Year)	Country)  W York
3		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limit
EXECUTIVE ITMET OF DOUBLES AT	tor	Maryland N/A		Baltimor					1 D Yes 2 DN
TO DO	Director	10e. Street and Number		Jul Clinor	10f. Zip Code		1	log. Citizen of What	
THE PERSON		830 West 40th Str	reet		212	:11		USA	
	Funeral	11. Marital Status 1 ☐ Never Married XX Married	12. Was Decedent Eve Armed Forces?		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.
and a	þ	3 ☐ Widowed 4 ☐ Divorced	1XXYes 2 ☐ No If Yes, Give Year or Dates:	WWII	1□Yes XXNo	Specify:		Specify:	White
	Completed	15. Decedent's Edu (Specify only highest grad	ucation	16a. De	cedent's Usual Occup	ation	ina	16b. Kind of Busines	ss/Industry
	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life	a. DO NOT use retired	t)	nig		
	e Co	17. Father's Name (First, Middle, Last)	5+	P	rofessor	18. Mother's Name	a (First Middle	<u>Univers</u>	sity
	To Be	Samuel	Tayb	ack		Freida	o (* 1101, 11110010, 1	maiden Guntaine)	
once.	-	19a. Informant's Name/Relationship (T		19b. Ma	ailing Address (Street	and Number or Rura	al Route Number	r, City or Town, State	, Zip Code)
9		Anita Moffat Tayba			West 40th	Street B	Baltimore	e, Marylar	nd 21211
1		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ I		cemetery, c	sposition (Name of rematory or other place	e)		20c. Location - City of	
		Donation 5 ☐ Other (Specify, 2), Signature of Funeral Service Licens	_ 1		unt Cemete			Baltimore,	Maryland
once		Denne Des	bo Kon	& Ben	22. Name and Addre	65.0 Vo	chell-Wied	lefeld Funera Illimore, Mar	al Home Inc
	1	23a. Part1. Enter the disease, or amp shock, or heart failure. List only o	lications that caused the	death. Do not	enter the mode of dyin				Approximate Interval Between
	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	onsequence of):					Onset and Death 15 Months
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _			23d. Date of d Month	elivery Day Year
-	Phys	9 Unknown	9□ Unknown						
	by	Part II. Other significant conditions co	intributing to death but n	ot resulting in the	underlying cause giv	en in Part I.		_	to the cause of death?  Probably 4 Unknow
	etec								
	Completed						24a. Was a autops perform	y prior to	autopsy findings available completion of cause of
	Ö	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2	2 No 1 ☐ Ye	s 2 No
-		23. Was case referred to medical		2 ER/Outpat	ient 3 DOA Oth	25	me 5 ☐ Reside		ecity) la maiens
	00	examiner?	Hospital: 1 Inpatient	2 L En Outpat	100 L				The state of the s
	To B	examiner?  1	28a. Date of Injury (Month, Day Ye	28b. Time lnjur	of 28c. Injury World M 1	yat (? Yes 2 □ No		w injury occurred	Hospice
	Certification; To B	examiner?    Yes   2 No	28a. Date of Injury (Month, Day Ye	28b. Time Injury At home, farm, Specify)	e of 28c. Injuny Work 1	y at √? Yes 2 □ No	28f. Location (Str City or Town	reet and Number or F n, State)	
	ai Certification; To B	examiner?  1	28a. Date of Injury (Month, Day Ye	At home, farm, Specify)  y knowledge, de amination and/or	o of 28c. Injury Work  M 1 :  Street, factory, office	y at (?? Yes 2 □ No	28f. Location (St City or Town	reet and Number or F	or stated
	Certification; To B	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only 2 Medical Exam	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (Section: To the best of miner: On the basis of exceptions)	At home, farm, pecify)  y knowledge, de amination and/or	e of y 28c. Injuny Work  M 1   Street, factory, office  wath occurred at the time investigation, in my office  29c. License	rat (? Yes 2 No  ne, date and place, sinion, death occurre number 7 74 59	28f. Location (Str. City or Town and due to the caed at the time, days	ause(s) and manner at and place, and du	as stated. se to the cause(s)
	edicai Certification; To B	examiner?  1 Yes 2 No  27. Manne of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (check only one)  1 Certifying Phy 2 Medical Examined	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (Section: To the best of miner: On the basis of example and manner stated of manner stated of the section of the basis of example the death of the section of the basis of example the section of the basis of example the section of the	At home, farm, pecify)  y knowledge, de amination and/or	e of Work Month 1 28c. Injun Work 1 street, factory, office stath occurred at the time investigation, in my of the stath occurred at the time investigation, in my of the state of the stat	rat (? Yes 2 No  ne, date and place, sinion, death occurre number 7 74 59	28f. Location (Str. City or Town and due to the caed at the time, days	ause(s) and manner at and place, and du	as stated. se to the cause(s)

			For State			nd / Depa	artme	nt of H	ealth a		ental Hygi	ene	O/	20500
			Registrar  1. Decedent's Name (First, Middle, Las	*)		Ce	rilica	te of E	Jeam		Re 2. Date of Death	g. No. <u>(</u>	114	3. Time of Death
	Physicia	ın	The state of the s								Month	Day	Year	S. Time of Dealit
	/Medic		Anna B. Wallac		umber)		4b. Cit	v. Town. or	Location of		Septembe	4c. County		3:30A
	Examin	er	28310 Thompson C						nanics		ما		. Mar	v's
	Funeral		5. Social Security Number 6. Se	ox	7. Age (In yrs.	last birthday)		er 1 Year	If Under 2		8. Date of Birth (Month, Day,			place (State or Foreign
	Director		248–52–8167	⊒M 2 <b>X</b> 0F		83 Yrs.	Month	Days	Hours		Nov. 11			
	pur &		Usuel Residence of Decedent  10a. State 10b. County		10c G	ty, Town or Lo	ncation							0d. Inside City Limits
	fanyla	5												1 ☐ Yes 2 No
	288-1	ect	Maryland St. M	lary's	Me	chanic		Le Lip C <i>o</i> de			16	g. Citizen of	What Cour	ntry?
	be filed within 72 hours after death with the Maryland stal Hygiene.  od other then "natural", or Items 23a or 28a-f show event, I'm Medical Exarting frigal by Indiffied at	by Funeral Director	28310 Thompson	Corne	r Rd				659					.,
	ms 2:	Jera	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Dec			in? (Spe	cify Yes or No- Rican, etc.)		ce - Ameno	cen Indian,
9	or Ite	큔	1 Never Married 2 Married	Armed F 1 ☐ Yes If Yes, G	2 No			2 No	Specify:	Pueno	ncan, etc.)	Specif	ck, White,	White
21215-0036	ural',	d b	3 Widowed 4 ☐ Divorced	Year or			10 103	2 140	Specify.					True -
5	natu	Completed	15. Decedent's Ed (Specify only highest grad		)	(Give	kind of v	ual Occupa work done d use retired;	uring most	of workir	ng 1	6b. Kind of B	lusiness/In	dustry
12	within ene. then	mo	Elementary/Secondary (0-12)	College	(1-4 <i>or</i> 5+)	1			,			3.6		
	Hygier ther		17. Father's Name (First, Middle, Last)			La	re G	iver	18. Mother	r's Name	(First, Middle, N		edical	
an	d be ental ked c	To Be	Charles Boudan	a					Mo	esod	y Elbaz			
Maryland	d 2 should be filed within in and Mental Hygiene. 7 le marked other then "treumatic event, it a Med	-	19a. Informant's Name/Relationship (7	уре, Print)		19b. Maili	ng Addre	ss (Street a			l Route Number,	City or Town	, State, Zip	Code)
	s 1 and 2 should f Health and Men Item 27 le marke other traumatic		Sarah Bedell/daugh	ter		2831	0 The	ompson	n Cor	ner 1	Rd., Mec	hanics	ville	e, MD 20659
ore,	of He		20a. Method of Disposition  1 K Burial 2 Cremation 3		20b.	Place of Disponent Competery, cre	osition (N	ame of other place	(s) Se	ept 0	77	20c. Location	-	
Ë	nit. Pages bartment of ortant: If I injury or		4 □ Donation 5 □ Other (Specify		Ar	Lingto	n Nat	tiona. ery	L	200	04 A	rlingt	on, V	7A
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 eny injury or other tra once.		21. Signature of Funeral Service Licen	50		2	2. Name	and Addres	s of Facility	Br	insfield	-Echol	s Fur	neral Home,
	40304		220 Part 1 Enter the disease or come	J Ja	caused the dea						Charlot		1, MI	Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. OV	each line.	r ()	ene							Interval Between Onset and Death
3760,	ate be executed hysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a conse									
.O. Box 68	it the death certificate by by the attending physis tached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	1 Live	utcome of pregn birth 2 ☐ Fet gnant at time of inown	al déath 3 [	⊒Ectopic ⊒ Other (	pregnancy specify)					ate of delive	ery Day Year
<u>a</u>	quires that n signed b uld be deta	by	Part II. Other significant conditions of	ontributing to	death but not re	sulting in the (	underlying	cause give	en in Part I.		23e. Did tob			he cause of death?
of Vital Records,	The law requires that the death rate has been signed by the atter page 2 should be detached for u	Completed									24a. Was ar autops perform 1 Yes 2	24b.	Were autoprior to codeath?	opsy findings available impletion of cause of
ita	Physician: rthis certifica ral director, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on		150	michiers
<b>1</b>	physic this ce al dire	To	1 Yes 2, No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 🗆 I	Othe Othe	9r: 4 □ Nu	rsing Hor	me 5 ☐ Reside	nce 6 🖔 Ot	her (Specif	no home
n o	ng (ftel		27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Dat (Mo	e of Injury onth, Day Year)	28b. Time of Injury		28c. Injury Work			28d. Describe ho	w injury occu	rred	
Division	Attending ir death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 □ N					
Ξ	or At ifter d Direct in by	E	4 Homicide determined	289. Pla	ce of Injury - At I Iding, etc. (Spec	home, farm, si ify)	reet, fact	ory, office		1	28t. Location (Sti City or Town	reet and Num , State)	ber or Rura	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo		29a. Certifier 1 Certifying Ph	veicien: To t	he heet of my l-	nowledge 455	th cocur	ad at the tim	no data acc	d place	and due to the	useo(c) and	200001	tatad
	Hos 24 hc Fun	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	niner: On the	ne best of my kn basis of examin anner stated.	ation and/or in	n occurre	on, in my of	pinion, deal	th occurr	and due to the ca ed at the time, da	use(s) and mate and place,	anner as s , and due t	o the cause(s)
	To the Within 2 To the comple	Mec	29b. Signature and title of certifier	2.10 1116	4 / 4		2	9c. License			25	d. Date signe	ed (Month,	Day, Year)
	⊢≯⊢ŏ		100	1	ell			HE	553	75	-1	9/11	4100	4
	1		30. Name and address of person who	completed ca	use of death (Ite	em 23a) (Type	, Print)							
	0		Jennifer Schmid	t. Cal	ifornia.	MD 20	619							
	St St	ate	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature	Kan	y. ,						
4	Regist	rar	SFP 2 0 2	2004	A Galler	So A	10							

			For State Registrar	State of M	aryland		rtment o			•	giene Reg. No.	004	29584
ī	Physici	an	1. Decedent's Name (First, Middle, La Clarence C. Whetstone	*						2. Date of De	ath Day	Year	3. Time of Death 4:11 P M
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	202			n, or Location		Septemb		County of Dea	
	Funeral		5. Social Security Number 6. S	of Baltin ex 7. Ag MM 2□F	je (In yrs. la:		If Under 1 Ye Months Da	ar If Unde	r 24 Hrs.	8. Date of Bir Month, Da 02-10-19	th Va Year)	NA 9. Bir	thplace (State or Foreign owntry) Ith Carolina
	Director		Usual Residence of Decedent	***						02-10-19	130	Sou	
	Maryla e-f ehov	tor	MD NA		Tue. City,	Town or Lo	Baltimo	re					10d. Inside City Limits 1 X Yes 2 □ No
	with the	Direc	10e. Street and Number 3708 Eldorado Avenue				10f. Zip Coo	ie 1207			10g. Citiz	zen of What C	ountry?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show simportant: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show ship injury or other traumatic event. It is Medical Exactinating the rollified at once.	y Funerai Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces 1 Ares 2 ☐ If Yes, Give		1	J	of Hispanic O Cuban, Mexica	an, Puerto	ecify Yes or No Rican, etc.)		USA 14. Race - Am Black, Whi	te, etc.
21215-0036	in 72 hours "natural", edical Ex	Completed by	3 ☐ Widowed 4 🏡 Divorced  15. Decedent's E.  (Specify only highest grade)	Year or Dates: ducation ade completed)		16a. Deced	lent's Usual Ockind of work do	cupation		ing		Specify: Bland of Business	
212	ed withi ygiene. ser than t, the M	Comp	Elementary/Secondary (0-12)	College (1-4or	5+)		bly Work	er					ors Corp.
Maryland	uld be fill fental H rked oth tic even	To Be	17. Father's Name (First, Middle, Last, Clarence C. Whetstone							o (First, Middle, ranklin	, Maiden	Sumame)	
Mary	12 shouh and M		19a. Informant's Name/Relationship (					eet and Numb	ber or Rura	I Route Numb			Zip Code)
	s 1 and if Health Item 27 other tr		Olivia Whetstone/ Daug		20b. Pla	Market Street, St. Street, St. St.	Sition (Name of natory or other			altimore, Date		1213 cation - City or	Town, State
Baltimore,	t. Pages tment of I rant: If It		1 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	y)	l	son For	est Vete	ran	9-24-0	04	Owing	s Mills,	MD
Bal	permit. Departr Importa		21. Signature of Funeral Service Licer	1500			Name and Ad Wlie Fun			N. Gilmo	r Str	eet Balt	imore, MD 21217
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each I	of the death.	Do not ente							Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as	a conseque	ence of):							
	ted nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a echeeque	anea ol).							
38760,	es that the death certificate be executed igned by the attending physician and be delached for use as the burial-transit	edicai Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):							
_	sertificat ding phy se as th		IF FEMALE:	23c. If yes, outcome	of pregnant	011							
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant a	2 Fetal c	death 3	Ectopic pregna Other (specify				2	3d. Date of de Month	livery Day Year
	w requires that been signed k should be deta	by	Part II. Other significant conditions of Hyperfension	contributing to death t	out not result	ting in the ur	nderlying cause	given in Part	1.			se contribute to	o the cause of death? robably 4 ©Unknown
Division of Vital Records,	The law re cate has be page 2 sho	Completed	1									24b. Were a prior to death?	utopsy findings available completion of cause of
Vita	siclan: certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 2 Inpati	on 20E	R/Outpatien	t 3 DOA	Other		(Check only o		C7011 (0	
ion of	nding Physiclan: The I ath: r: After this certificate ha e funeral director, page	H- }	27. Manner of Death  1 (Chatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	Irv 2	28b. Time of Injury	28c. I	njury at Work? 1 🗌 Yes 2	1	me 5 🗍 Residente l			icity)
Divis	To the Hospital or Attent within 24 hours after death to the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of in	jury - At hom tc. (Specify)	ne, farm, str	eet, factory, off	ice		28f. Location ( City or To	Street and wn, State)	i Number or R	ural Route Number,
	he Hospit n 24 hours he Funere pletely fille	edicai (	29a. Certifier 1 Le Certifying Pl (Check only one) 2 ☐ Medical Example (Check only one)	nysician: To the best miner: On the basis of and manner s	of examinatio	rledge, death on and/or inv	occurred at the	e time, date a ny opinion, de	nd place, a	and due to the ed at the time,	cause(s) date and	and manner a place, and due	s stated. e to the cause(s)
ı	To t Withi To tl	Σ	29b. Signature and title of certifier	· AA			1	ense number				signed (Mont	
•	14		30. Name and address of person who	completed cause of	death (Item 2	23a) (Type,	Print)	3-000			Sep	KIII DC	18,2004.
	11.	to	Han S Chayee, D.O. 31. Date filed (Month, Day, Year)	Sinai Hosi	ntal of	Balt	more, 2	40/ West	Belve	dere Ba	/timo	re, Man	land 21215
	Sta Registi		SFP 2.0.20	A.	-	2 1	and s						

Clarence Whetstone

l		-	For State Registrar	State of Maryland	•	tificate of			gierie Reg. No. () (		29685
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ELOISE J. WEAT					2. Date of De Month SEPT.	Day	Year 0 0 4	3. Time of Death 1:54p M
	Examin	er	4a. Facility Name (If not institution, give of SINAI HOSPITAL 5. Social Security Number 6. Sec.	7. Age (In yrs. la			r Location of Death TIMORE C If Under 24 Hrs. Hours Min.	TTY	4c. County	9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent  10a. State 10b. County		Yrs.	cation	Hours Mills.	03704	[/1933]	VIRO	GINIA  10d. Inside City Limits
	In the Mar or 28e-f s e notified	lrector	10e. Street and Number	ORE CITY	BALT	10f. Zip Code			10g. Citizen of \	What Cou	1 XYes 2 No ntry?
20	s 1 and 2 should be filed within 72 hours after death with the Maryland f Healith and Meaharl Hygiene. f Healith and Meaharl Hygiene. other treumatic event, the Mealital Existing of must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1  ☐ Yes		2 1 2  Was Decedent of H  f Yes, specify Cub.	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	USA 14. Rac Blac Specify	ce - Americk, White,	can Indian, etc. I TE
0-6121	e filed within 72 hou il Hygiene. other than "nature ent, the Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of world)	king	16b. Kind of B	usiness/In	ndustry
ylailu r	should be filed with ind Mental Hygiene. s marked other than umatic event, the N	To Be Co	17. Father's Name (First, Middle, Last)  JERVIS S. JANN	EY			18. Mother's Nam	TH HII	Maiden Suman	ne)	
_	s 1 and 2 sho if Health and item 27 Is m other treum		19a. Informant's Name/Relationship (T)  LYLE BENSON ( P •  20a. Method of Disposition	O.A.)	1107	•	And Number or Ru			212	204.
	permit. Pages Department of t Importent: If ite any injury or of once.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State ST	THC	MAS G. Name and Addre	FORESTO	& SON	2004 OW	INGS	S MILLS,M
2.	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.  a	logu	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
8/00,	tificate be executed g physician and as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence)							
C. BOX 0	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnanc Other (specify)	у			te of deliv	rery Day Year
٠ <u>.</u>	w requires that the bear signed by should be detact	by	Part II. Other significant conditions co	entributing to death but not resu	olting in the u	nderlying cause gr	ven in Part I.		tobacco use coni Yes 2 □ No	tribute to t	the cause of death?
al Hecords	The law ate has b page 2 sl	Completed						1 Yes	prsy ormed? 2 No	Were auto prior to co death? 1 X Yes	opsy findings available ompletion of cause of
Division of Vital	utending Physideath. ctor: After this y the funeral di	Certification; To Be	27. Manner of Death  1 Natural 5 Pending  2 X Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)  1504  28e. Place of Injury - At ho	28b. Time of Injury	f 28c. Inju		ome 5 Resi	idence 6 Oth	ined Sul	byject druce wealor Accept
S	To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	edical Certif	4 Homicide determined  29a. Certifier 1 Certifying Phyone Check only one 2 Medical Exem	building, etc. (Specify	duras	h occurred at the t	ime, date and place opinion, death occu	City or To	tone of cause(s) and m	O MA COM anner as s	Horas Star
)	To the within. To the comple	Med	29b. Signature and title of certifier	7.Kgm		29c. Licen			29d. Date signe		Day, Year) 16,2004
	D		30. Name and address of person who of THEODORE M. KI				IMORE, M	D. 212	01.		

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SEP 2 0 2004

ORIGINAL

32 degistrar's Signature

			1 - For State Registrar	State of I	Maryland / I		rtment tificate			nd M	ental Hy	giene	01.	200	9.0
	Physici		1. Decedent's Name (First, Middle, La MARY VIRGINIA	st) WILLIAM	IS						2. Date of De Month Septen	nber 15,	Year 200/	3. Time of D 7:10P	eath M
	/Medio Examir		4a. Facility Name (If not institution, given The Wesley						Location o	f Death	оср ссп	4c. County			
	Funeral Director		5. Social Security Number 6. S 216-07-0090 Usual Residence of Decedent		Age (In yrs. last bi	Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da February	<sup>th</sup> 20,1913	9. Birthi Cour Mary	place (State or a ntry) / land	Foreign
	e Maryland Sa-f show diffed at	ctor	10a. State 10b. County  Maryland N/A		10c. City, Tow	vn or Loc								Nod. Inside City	
	h with th	ai Director	10e. Street and Number 2211 West Rogers	Avenue			10f. Zip (	<sup>200</sup>	)9			10g. Citizen of USA	What Coul	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be molified at QRCs.	by Funeral	11. Marital Status  XXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	ss? XNo	1	Vas Decede Yes, specif		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)		ck, White,		
Maryland 21215-0036	within 72 ho iene. than "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			(Give I life. D	ent's Usual kind of work OONOT use	done di retired)	uring most	of workin	g	16b. Kind of B			-
nd 2	be filed stai Hyg od other event,	Be C	17. Father's Name (First, Middle, Last,				UUI_K		18. Mother			, Maiden Suman	rinti 'e)	ng	
aryla	should and Mer marke umatic	<sup>L</sup>	John Wesley Will: 19a. Informant's Name/Relationship (	Type, Print)	198	b. Mailing	g Address (	Street a	nd Number	or Rural	aude Re	er, City or Town,	State, Zip	Code)	
e, K	1 and 2 Health a em 27 is		Robert W Schaefer	<u> </u>	Ousin 5	903	Meado	WOOC	Road	d Bal	timore	e, Maryl	and 2	1212	
Baltimore,	Pages nent of I int: if it		X X Burial 2 ☐ Cremation 3 ☐ 4☐ Donation 5 ☐ Other (Specif		comoto	ary, crem	atory or oth	er place	· 1	9/18/		Baltimo			1
Balt	permit. Departr Imports eny injt		21 Agnature of Funeral Service Licer	Mena	kes		Name and		s of Facility 650	Mit O Yor	chell-Wi k Road B	edefeld F altimore,	uneral	Home Inc	С
8760,	Medical Examiner the buriar-transit	dical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	sed the death. Do h line.  +++P+2 as a consequence as a consequence as a consequence	of):	1 FA2	CT	DE	m E	ntia			Approximate Interval Between Onset and De	
.O. Box 68	death certifi e attending I ed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 Fetal death t at time of death		Ectopic pred Other (spec					23d. Dat Mo	e of delive	ry Day Yea	ar
Φ.	es ign	ğ	Part II. Other significant conditions of Phenatonal As	ontributing to death	h but not resulting i	in the un	-	ise givei		~	23e. Did t	obacco use conti		e cause of dea	
Division of Vital Records,	The law ate has b page 2 s	Completed								_	24a. Was autor perfo 1 \( \text{Yes} \)	rmed?	rior to cor leath?	osy findings avanted in the second se	allable se of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※ No	Hospital: 1 ☐ Inpa	atient 2□ER/Ou	utpatient	3□ DOA	Other			(Check only o	ne) dence 6 □Oth	or (Specifi		
sion of	ding h. After fune	ertification: T	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of li (Month, i	njury 28b.	Time of Injury		. Injury Work		21		now injury occurr		7	
DIX	al or Attens safter death in Director; od in by the	Certifi	3 Suicide 6 Could not b 4 Homicide determined	289. Place of	Injury - At home, fa etc. (Specify)	arm, stre	et, factory,	office		2	Bf. Location (S City or Tox	Street and Number vn, State)	er or Rura	Route Numbe	r,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai (	29a. Certifier Check only one) Certifying Ph	ysician: To the be niner: On the basis and manner	s of examination ar	e, death nd/or inve	occurred at estigation, it	the time	e, date and nion, death	place, ar	nd due to the	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)	
	To the I within 2 To the I complet	ž	29b. Signature and title of certifier	A sale				License				29d. Date signed	,	Day, Year)	
	0		30. Name and address of person who ROBERT LIBERTO.	completed cause of	of death (Item 23a)	(Type, P	Print)	י האה המ	1461	. N	ne .	9/171 2122	04		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 0 2004	32. Regi	strar's Signature	L	racks	1	, -10	<del></del>	7	,,,,,	*		

DHMH 17 Rev 1/2001

WILLIAMS, VIRGINIA

Registrar

DHMH 17 Rev 1/2001

30. Name and address

31. Date filed (Month, Day, Year)

SEP 2 1 2004

111 Penn Street, Baltimore, Maryland 21201

eted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

		ļ	1 - For State Registrar	State of Maryla	and / Depa		ealth and M	ental Hygie	ene	20000
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Las  GERALD i  4a. Facility Name (If not institution, give	NE	. 0	Lown 4b. City, Town, or L		2. Date of Death Month	Day Year  S 2004  4c. County of Death	3. Time of Death
	Funeral Director	ier	2502 WES 5. Social Security Number 6. Se 214-40-0057	T PRATT.	ST. rs. last birthday) Yrs.	(20	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y.	ear) 9. Birth	Paper (State or Foreign Intry) Pifical AND
	with the Maryland a or 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  MARYLAND 10e. Street and Number	10c.	City, Town or Lo	Cation  BALT  10f. Zip Code	HORE		. Citizen of What Cou	10d. Inside City Limits 1 ✓ Yes 2 ☐ No
36	s after death or Items 23	by Funeral	2502 WES7  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	PRATTION  12. Was Decedent Ever in Amed Forces?  1   Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of His i Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto F	3	14. Race - Amer Black, White	ican Indian, , etc.
3 21215-0036	d within 72 giene. ir then "nai	Completed	15. Decedent's Ed (Specify only highest grau  Elementary/Secondary (0-12)  THGRADE  17. Father's Name (First, Middle, Last)	ication	(Give	lent's Usual Occupati kind of work done du DO NOT use retired)	iring most of workir SUPERVI	50R S	b. Kind of Business/Ir	
Maryland	2 should be and Menta Is marked aumatic ev	To Be	PRESTON  19a. Informant's Name/Relationship (7	1/2	BRO	ww	MARI		ity or Town, State, Zi	1 MS 0 Code)
Baltimore,	permit. Pages 1 and in Department of Health Importent: If item 27 eny injury or other trence.		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify  21. Sign turn of Funer I Service Center)	K	INC ME	sition (Name of natory or other place)  M. PARK  Name and Address  S. S. S. P. H.  The mode of things	19.5	E 14/1	C. Location - City or T C. Location - City or T C. CODLAW R. FUNG	N MARYLAND
}	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ilications that caused the de- ine cause on each line.  a. Me es Due to (or as a cons	tatic	and mode of dying,	such as cardiac of	(espiratory arrest,	BALTO, M	Approximate Interval Between Onset and Death
1760,	ite be executed sysician and ne burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to without a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons  c. Due to (or as a cons  d						
.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3 [	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
Records, P.	v requires been sign should be	Completed by Ph	Part II. Other significant conditions co	ntributing to death but not r	esulting in the ur	derlying cause given	în Part I.	23e. Did tobace		he cause of death?  pably 4 Unknown  ppsy findings available
Vital	ysicien: is certifica director, p	To Be Comp	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	0.0	26. Place of Death	autopsy performed 1 Yes 24 (Check only one)	prior to co death?	mpletion of cause of 2 No
Division of	Jing After fune	Certification:	27. Manner of Death  Natural 2 Accident 3 Suicide 4 Homicide  2 Natural 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spe	home, farm, stre		es 2 🗆 No	8d. Describe how i	njury occurred t and Number or Rura	
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	one)	sician: To the best of my kiner: On the basis of exami and manner stated.	rnowledge, death	estigation, in my opin	nion, death occurre	nd due to the cause d at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	of with the contract of the co	2	29b. Signature and title of certifier  30. Name and address of person who c	ompleted cause of death (It	em 23a) (Type, I	29c. License n P35		29d.	Date signed (Month,	Day, Year)
	Sta Regist		Canala Miller S 31. Date filed (Month, Day, Year)	32. Registrar's Sig	100	BALLINIO	re M	P 212	29	
DHI	MH 17 Rev 1/2	001	SEP 2 1 2004	Millian D	ORIGINA	L				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Allen Butts Sept. 2004 /Medical 13, 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Localion of Death 4c. County of Deeth 2413 Eugene St. Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplece (State or Foreign Country) Hours 1**∑**M 2□ F Director 522-48-2495 64 Oct. 20,1939 Colorado Usual Residence of Decedent filed within 72 hours after deeth with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Iteme 23a or 28a-f shot other traumatic event, the Madical Exemples mast be notified at Director MD1 ☐ Yes 2 ☐ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2413 Eugene St. 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant / Controller Pages 1 and 2 should be filed venent of Health and Mental Hygie and: If Item 27 is marked other t Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Billy Butts Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra G. Butts / Wife 2413 Eugene St., Silver Spring, MD 20902 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate Department of H Importent: If Ite any injury or ot 1 Bunal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Sept. Chesapeake Crmatory 2004 Beltsville, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic Carcinoma 12 months /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial transit resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Wes decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 Be Completed 1 ☐ Yes XXNo 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2XX\\\0 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home XXResidence 6 Other (Specify) 1 ☐ Yes 2√ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred or Attending 1XXiatural 5 Pending death. investigation 1 Tyes 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23308 eller trugo, mo September 14, 2004 10 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Victor M. Priego, M.D. 6420 Rockledge Dr. \$4100, Bethesda, MD 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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			1 - For Unpend Item 1 - Stata Registrar	#23a,pt.	il,27 per	partmer Title G8 ertificat	35 5	Pzylo	and M	ental Hyg	jiene	00000	
			negistrar     Decedent's Name (First, Middle, La			or arroa	COL	- Call		2. Date of Dea		4 (37.71)	
	Physici	an	1. Decedent's Name (First, Middle, La		1.1511	7	_			Month		3. Time of Death	
	/Medic		LEON	1241C	SWELL		R.			Septembe	er 18, 2	2004 8:17 A M	
	Examir	ner	4a. Facility Name (If not institution, giv	e street and number)		4b. City,	Town, or	Location of	of Death		4c. County of	of Death	
01			1835 N. Dallas St	reet		В	altir	more			N	N/A	
0	Funeral		5. Social Security Number 6. S		e (In yrs. last birthde	y) If Under	1 Year	If Under		8. Date of Birth (Month, Day)		9. Birthplace (State or Foreign	7
3	Director		216-56-8446	MM 2□F	5 <i>Q</i> Yrs.	Months	Days	Hours	Min.	JUNE 5	1952	MARYIAND	
7	70		Usual Residence of Decedent							00/10 0/	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	MAICHEN	_
	show		10a. State 10b. County		10c. City, Town or	Location					<u>.</u> .	10d. Inside City Limits	
	Man	ō	MARYLAND N/A		BALT	ime	DRE	-				1 <b>X</b> Yes 2 □ No	
	ith the Maryla or 28a-f sho	ec	10e. Street and Number			10f. Zic				1	0g. Citizen of W	hat Country?	_
	with o	Ω	1835 N. DALL	AS 57	REET	1		13			115	A Country:	
	sath	by Funeral Director		12. Was Decedent					ain2 /Can	aifu Vaa au Na	14 8000	American Indian	_
	er d	Ē	11. Marital Status	Armed Forces?		If Yes, spe	cify Cuba	n, Mexican	n, Puerto F	cify Yes or No- Rican, etc.)		- American Indian, c, White, etc.	
36	s at	Ž	1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 I If Yes, Give Year or Dates:	140	1 🗆 Yes	2 <b>X</b> No	Specify:			Specify:	BIACK	
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5	I within 7: liene. r then 'n	ם	Elementary/Secondary (0-12)	College (1-4or	5+)	200		,		1	TOHILL	Y ROCKETS	
2	71 72 4 4	ပိ	12 TH GRADE  17. Father's Name (First, Middle, Last,			<u></u>	717	40.14.4	1 1				_
Ĕ	be fi	Be	17. Patriot s Name (First, Middle, Last,	BAGLIXE	-//						Maiden Sumame	f	
N S	should and Men marke umaric	၉	LEON					VIR				RTSON	
Maryland 21215-0036	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other treumatic event,		19a. Informant's Name/Relationship (								City or Town, S		£
	s 1 and 2 if Health a item 27 is other tree		JANICE BAGWE	LL (WIFE	) 714	IT IARTI	NLU	THER	KIN	C JR. BL	VD, BAL	TD, MD 21201	1
Baltimore,	es 1 ar of Hea fitem rothe		20a. Method of Disposition		20b. Place of Dis	position (Nar	ne of other place	e)	D	ate	20c. Location - C	City or Town, State	
Ĕ	Page ent o nt: If ry or		1 🗷 Burial 2 □ Cremation 3 □  `4 □ Donation 5 □ Other (Specif						9-24	-2004 C	ROWNSV	ILLE, MARYLAND	>
星	nit. Pa artmen ortent; injury e.		21. Signature of Funeral Service Licer	•	44	22 Name of	al Address	a of Facility					-
B	permit. Page: Department of Importent: If is any injury or once.		) Dicherch	N.11 )11	Pinma 5	OSEPH	H.	BROW	W	JR FU	NERAL .	HOME	
			23a. Part1. Enter the disease, or com	olications that cause							MUREIN	ND QIQI7 Approximate	_
_ #			snock, or neart failure. List only	one cause on each i	ne.						551,	Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	ATHEROS	SCLEROTIC	CARDIO	OVASC	JULAR	DISE	EASE		Orisot and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								_
			Sequentially list conditions	b									
	ם =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
	be executed ician and burial-transit	ami	that initiated events	c									
ó	an al		resulting in death) Last	Due to (or as	a consequence of):								
160	te be ex ysician ne burial	cal	(	d								_	
68	Physicien: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medical											
Вох	ndin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	of delivery	
m	leath atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant a		B□Ectopic pr B□ Other <i>(sp</i>					Mont	-	
P.O.	that the death cer ed by the attendin detached for use	lys!	9 Unknown	9□ Unknown			,,						
۵	that the ed by detac		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	undertving c	ause give	n in Part I.		23e. Did tob	acco use contrib	oute to the cause of death?	
Division of Vital Records,	signed I	Completed by	DIABETES MELLITU			, ,						B Probably 4 □Unknown	
O	w requir	etec	CITONITO NADGOMIO		·						7		
ec	e law has b	pldc	CHRONIC NARCOTIS	M						24a. Was ar autops		ere autopsy findings available for to completion of cause of	
Щ.	The Tate has page	ő								perform	ned? de	atb? Gres 2 No	
ita	ilcien: Th certificate rector, pag	Be (	25. Was case referred to medical					26. Place	of Death	(Check only one			_
>	ysicien: Is certific director,	To E	examiner?  Yes 2 No	Hospital:	ent 2 ER/Outpat	ent 3 DC	A Othe	r: 4 Nu	rsina Hom	e 5∏Reside	nce 6 <b>∑</b> Other	(Specify) at access	
ō	ding Phys n. After this funeral di		27. Manner of Death	28a. Date of Inju (Month, Da			8c. Injury Work				w injury occurred		-
0	th: After	ti Oi	1 ☐ Accident 5 ☐ Pending 2 ☐ Accident investigation		y Year) Injun	М		7 ′es 2 □ N	No				
S	Attending r death.  ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	28e, Place of Ini	ury - At home, farm,	street factors	office		2	8f. Location (Str	reet and Number	or Rural Route Number,	_
Š	or / after Dire	Certification;	4  Homicide	building, et	c. (Specify)	, , , , ,	,			City or Town	, State)		
_	pite ours erel filled		29a. Certifier 1 ☐ Certifying Ph	veicien: To the best	of my knowledge, do	ath assumed	- 4 4 5 - 4		1 -1				
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical		ysician: To the best niner: On the basis o	f examination and/or	ath occurred investigation,	at the time in my op	e, d <i>a</i> te and inion, deat	a piace, ar th occurre	nd due to the ca d at the time, da	iuse(s) and manr ite and place, an	ner as stated. Ind due to the cause(s)	
	within 2 within 2 To the	Med	29b. Signature and title of certifier	and manner st	ateu.	200	License	oumbor.		200	Od Data singed	(Month, Day, Year)	_
	F ≥ F 8	_	23b. Signature and the of contino			250	. CIVETISO	Hamber		23	ou. Date signed (	(MOIIII, Day, real)	
				Min	)		(	O.C.M	LE.	Se	eptember	19, 2004	
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Typ	e, Print)							
		les-	MARIE RIPPL	Sno	111	Penn	Stre	et, B	altir	more, Ma	aryland	21201	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature					-			$\exists$
	Registi	rar	SEP 2 1 2	nna h	OPIGIN	4	/						
DH	VIH 17 Rev 1/2	001				14	Dock	2					
					ORIGIN	IAL							

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death Thyear 3. Time of Death Decedent's Name (First, Middle, Last) Day · 10 AM **Physician** 20 2004 Deptember /Medical 4a. Facility Name (If patinstitution, give street and number)
Baltimore Keha bilitation and Extended
Care Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (la yrs. last birthday)

Yrs. Sex 1X0 M 2□F (Vairthplace country) State or Fareign **Funeral** Months Days Hours Min Director 09/07/1919 Usual Residence of Decedent the Maryland 10b. County 10d Inside City Limits or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No timote 11a Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 12. Was Decedent Eve Amped Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status LHW 1 Never Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify 3 Widowed "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working the DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. (Secondary (0-12) College (1-4or 5+) Name (First., Middle, Majden Sumame) 17. Fathler's Name (First, Middle, Last) 18. Be 10 Name/Relationship (Type, ss (Streekar 20c. Location 20a. Method of Disposition 0 = 0 Burial 2 Cremation 3 Removal from State Burial 2 Cremano. 4 Donation 5 Other (Specify) Department of Importent: If any injury or 21. Signature of Funeral Service Lightse terration leater Fuberal 4 once. 23a. Part1. Enter the disease, dr con shock, or heart failure. Lift only 21093 Timonium 101 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dy o, such as care ac or respiratory arrest. Immediate Cause (Final disease or condition Physician Due to (or as a consequence of) 51 ancer /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bissise figure) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-I P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Division of Vital Records. Completed by 3 Probably 4 Unknown 2 🗆 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 \textbf{\textit{Z}} No has page certificate 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner?

1 Tyes 2 No 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 2 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? uneral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident in by the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ani M ,2004 Deptem 20 Baltimore of death (Item 23a) (Type, Print Name address of person Aurora 3900 L och Kaven 21218 Doulevard 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Rag. No. State Ragistra AMEND ITEM #8&8 PER FH G835 9/24/1904 tempf Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 06:45 AM September **Physician** Bankard 18 2004 Walter /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Baltimore Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 1945 (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** 219-44-9540 10 M 2□F 59 MARYL Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or flems 23a or 28a-f shot traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No by Funeral Director MS SALTI MORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 Was Decedent Ever in U.S. Armed Forces? 1/X/Yes 2 ∐No I/Yes, Give Year or Dates: 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White. Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) \* Fender Mental Hygiene. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be SchieRer. Margaret DAN KaRA 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Baltimore, Health a Barbara SISTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition rtment of 1 Burial 2 Cremation 3 Removal from State = njury or 104 PARKVILLE Department Important: If any Injury o More land Mom. Park 4 □ Donation 5 □ Other (Specify) PARKVILLE, MA 21234. 21. Signature of Funeral Service Licensee Simbelle EVANS FUNERAL CHAPEL, 8800 HARFURD R.D. S hal caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Pa 1. Enter the disease, o complication shock, or hear failure. List only one call Immediate Cause ( inal disease or condition resulting in death) acute 4 years myelogenous leukemig **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by vancomycin-resistant 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Enterococca 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 No 1 ☐ Yes 2 X No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1.☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation neral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ▶ angeline Chorg, Medical Doctor September 18,2004 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Angeline Chong, The Johns Hopkins Hospital, 600 North Welfe Street, Baltimore, Maryland 21287 32/Registrar's Signature 31. Date filed (Most) Cay, Xear) 2004 State Registrar

		1	State of Maryland / Department of Health and Mental Hygiene    - State Registrar	2
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)  ARTHUR BRINKWORTH  2. Date of Death Month Day Year 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	J.M
	/Medic Examin Funeral Director	er .	4a. Facility Name (If not institution, give street and number)  Nonthality Name (If not institution, give street and number)  4b. City, Town, or Location of Death  RANDALLS Town  PANDALLS Town  Ball Trucks  Ball Trucks  Country)  9. Birthplace (State or Formath)  Months Days Hours Min. (Month, Day, Year)  April 23 1912  NY	oreign
	ס		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	
	with the 1 3a or 28a-	I Direct	10e. Street and Number 7426 Sykesville Road 10f. Zip Code USA 10g. Citizen of What Country?	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumetic event, The Medical Exatts are must be notified at Ance.	by Fur	11. Marital Status  1	
21215-0036	I within 72 hou jene. r than "naturi r he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  NY Telephone Co.	
Maryland	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Arthur Brinkworth  18. Mother's Name (First, Middle, Maiden Sumame) Anna Baumann	
, Mary	and 2 shorestith and An 27 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5221 Stone Mill Ct., Eldersburg, Md 21784	
Baltimore,	Pages 1: nent of He ent: If iten ury or oth		20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of Alf County Crematory or other place)  Alf County Crematory or other place)  20c. Location - City or Town, State Sykesville, Md	
Balt	permit. Departi		21. Signature of Funeral Service Licensee  Page Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate	
58760,	Physician /Medical Examiner  physician and physician and physician are stife phrial-transit	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   th	
.O. Box 6	death certifies attending	Physician/Me	IFFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)	r
S, P	de ed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death  1 Yes 2 No 3 Probably 4 Dunk	
I Record	The law requires ate has been sign page 2 should be	Completed	CENCESTIVE HEART FAILIRE RENAL INSUFF GENCE 24a. Was an autopsy performed?  MIERIOSCLEROFIC CARDIOVASCULAR DISERSE 1 Yes 2 DAG 1 Yes 2 DAG	ilable e of
lon of Vital	ing Physicien: After this certific iuneral director,	To Be	25. Was case referred to medical examiner?  Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner Death 1 Residence 5 Other (Month, Day Year)  28b. Time of Injury at Work?  M 1 Yes 2 No	
Division	5 5 # 6	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office City or Town, State)	;
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical C	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within To the comp	M	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	e d
-	O,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ORIANDO B. CONANAN MD  PHODALISTERN ML  21133	
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 1 2004  32. Phistrar's Signature  SEP 2 1 2004	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2450 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** EDWIN BOOTH 0:55 SEPTEMBER /Medical 16 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CENTRE BALTIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1⊠M 2□F Months Yrs. Director 212-05-6915 85 11, 1918 Maryland Usual Residence of Deceden Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, it e Madical Examiner must be notified at 1x Yes 2 □ No Director Maryland Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Boswell Road 21229 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give WW II Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WW II à Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Heelth and Mental Hyglene. Importent: if Item 27 is marked other than "rapy injury or other treumatic event, Ite MAS 2008. Elementary/Secondary (0-12) College (1-4or 5+) 8 Huckster Produce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Booth Augusta Neubert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Booth (Wife) 215 Boswell Road Baltimore Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 9-20-2004 Baltimore, Maryland ^ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave. Catonsville, Maryland Dema 21228 23a. Part1. Enter the disease, or combigations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) MYOCARDIAL INFARCTION 4 days ACUTE INFERIOR WALL /Medical Due to (or as a consequence of) Examiner Securentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown DIABETES HELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death? GASTRO INTESTINAL BLEEDING autopsy performed? 1 ☐ Yes 2 ☑ No 2 No 1 Yes Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) funaral 27. Manner of Death 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident e aftar death 6 Could not be determined 3 🗀 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funarel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier MADWAVI. MADALA 29c. License number 29d. Date signed (Month, Day, Year) Machan (HOUSE OFFICER) SCPTEMBER RES 000 16 2004 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/ Tarbor 40SD1 Hanover 31. Date liled (Month, Day, Year) 32\_egistrar's Signature State SEP 2 1 2004 Registrar

Hospital or Attanding Division within 24 hours a To the Funaral C

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

SEP 2 1 2004

Medicai

THEODORF Miking 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner setted.

29c. License number

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

SEPT. 16, 2004

			State Registrar			Cert	ificate of	Death			Reg. No.	AL.	2950	36
	Physici	an	1. Decedent's Name (First, Middle, La	St) A so	Rr	ook	<	-	:	Date of De Month	Day	Year	3. Time of D	
	/Medic	al	4a. Facility Name (If not institution, giv	a street and number)	1)10	2011	4b. City, Town, o	or Location of	f Death	09		2004 ity of Death	0611	14
	Examin	er	North Arunde		Inti		Glen B			D		ARI		
	Funeral		Social Security Number     6. S	Sex 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 2		B. Date of Bi (Month, Di -16-1		9. Birth	place (State or I	-oreign
	Director	ļ	213-30-2332	□M 257F	71	Yrs.		1100.0		16-1	933 ′			
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Fown or Loc	ation						10d. Inside City	Limits
	Maryl -fehc	to	MD Anne Ar	unde1	]	Pasade	na						1 Tyes 2	X No
	r 286	irec	10e. Street and Number				10f. Zip Code				10g. Citizen o	f What Cou	untry?	
	th witi	ai D	1818 Parkside Dr	ive			21122				1	USA		
	r dea	uner	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of H Yes, specify Cub	lispanic Orig an, Mexican,	gin? (Spec , Puerto R	ify Yes or Nican, etc.)	o- 14. R B	ace - Amer lack, White	ican Indian, , etc.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f ehow other traumatic event. The Madical Examinational be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N If Yes, Give Year or Dates:	lo	1	□Yes 2X No	Specify:			Spec	cify: w	hite	
21215-0036	2 hou	ted 1	15. Decedent's E	ducation		16a. Decede	nt's Usual Occup	pation	- #		16b. Kind of	Business/I	ndustry	
215	within 7. ene. then "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	+)		ind of work done O NOT use retire		or working	9				
21	filed wi Hygien other th		12			Kec	eptionis		d. Ma	(C)		ledica	ı.L	
Maryland	2 should be filed within and Mental Hygiene. is marked other then aumatic event, the Ma	Be	17. Father's Name (First, Middle, Last George Henr							thy A	e, Maiden Sum 1 mond	ame)		
Z	should nd Men marke imatic	၉	19a. Informant's Name/Relationship			19b. Mailing	Address (Street					m. State. Z	ip Code)	
	and 2 s lealth ar m 27 is her trau		Mrs. Linda Rogers	/daughter		244 M	chele C	ir., M	iille:	rsvill	e MD 21	108		
Je,	of Head		20a. Method of Disposition	7D	20b. Plac	e of Dispos	ition (Name of atory or other pla	ce)	Da		20c. Location	n - City or 1	Town, State	
Ë	Pages nent of I ent: if its ury or o		1 X Burial 2 ☐ Cremation 3 ☐  14		Glen		Cemete	- 9	/23/2		Glen B			
Baltimore,	permit. Pages 1 au Department of Hea Importent: if item any injury or othe once.		21. Since ture of June al Service Lice	nsee/	M0136	22.	Name and Addre	ess of Facility	Sing	leton	Funera	1 Hom	e P.A.	
	00 = e 0		23a, Part1. Enter the disease, or con	UCY		, ,	Second A	ve sw	GTEII	burn	ie MD Z	1061	Approximate	
			shock, or heart failure. List only	one cause on each lin	10.			_		respiratory o	211631,		Interval Betwee	en ath
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	a conseque	ell	Lung	(Anc	er					
ш	Examiner			200 10 (0. 40 .	u 001100qu01	100 01).								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseque	nce of):								
	and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	2.000000000	non of):								
60,	be exician girial		in the same of the	D00 t0 (b) 25 t	a consequen	nce or).								
68760	certificate be executed iding physician and ise as the burial-transit	/Medical		_ d										
X	anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnanc					Date of delin		
B	death ne atten ed for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at			Other (specify)	y 			,	Month	Day Ye	ar
P.0	requires that the death c een signed by the atten nould be detached for u:	by Physicia	9 Unknown Part II. Other significant conditions		ut mat raquiti	na in the con	darbrian anung ni	on in Dort I		23a Did	tobacco use co	intributo to	the cause of dea	ath?
Ś	w requires that s been signed t should be det		Part II. Other significant conditions	contributing to death bu	ut not resum	ng in the uni	renying cause giv	ven m Faiti.			Yes 2 No		bably 4 🗆 Un	
Ö		etec								24a. Wa	s an   24h	Ware aut	onsy findings av	allahla
Rec	has Je 2	ompieted								auto	opsy ormed?	prior to o death?	opsy findings av	ise of
a	i <b>cien:</b> Th certificate rector, pag	e C	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes Check only	2 No one)	1 🗆 Yes	2 No	
ţ	S .2 5	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	nt 2 EF	VOutpatient	3□ DOA Ott	ner: 4□ Nur	rsing Hom	e 5 Res	idence 6 🗆 C	ther (Spec	ify)	
Division of Vital Records,	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	ry Year) 21	8b. Time of Injury	28c. Inju	rk?		d. Describe	how injury occ	urred		
Sio	Attending r death.	cati	2 Accident investigated 3 Suicide 6 Could not	00 00 01 00	unr. At hom	a farm etra		Yes 2□N		of Location	/Street and Nur	nher or Pu	ral Route Numbe	27
ίΣ	spitel or At ours after c nerel Direct filled in by	Certification:	4 Homicide determined	building, etc	c. (Specify)	o, iaiiii, stie	et, ractory, office		20	City or To	wn, State)	IIDai oi Hui	ar rioute rearribe	<i>u</i> ,
_	To the Hospitei or Attenwithin 24 hours after deali To the Funerel Director: completely filled in by the		29a. Certifier 1 ☐ Certifying P	nysicien: To the best of	of my knowle	edge, death	occurred at the ti	me, date and	d place, ar	nd due to the	cause(s) and	manner as	stated.	
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical Exa	miner: On the basis of and manner sta		n and/or inve	estigation, in my	opinion, deat	th occurre	at the time				
	To t To t	Σ	29b. Signature and title of certifier	)			29c. Licens		-		29d. Date sign			
•	21		Hen L	tran un				1741	5		9/18/	200	) T	
ť	2 "		30. Name and address of person who	completed cause of de				001	Hospi	tal				
	Sta	at <u>e</u>	31. Date filed (Month, Day, Year)	36. Registra	ar's Signatur	8	Arun	701	11- 211	/ ") (				
	Regist		SEP 2 1 201	14 Serve	, 15.	1700								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

G			1 - For State Registrar		State of Ma	aryland	d / Dep	artmer	nt of H			Mental Hy		•	e.	29697
ı	Physic		1. Decedent's Nam George	e (First, Middle, Las Roger	Black	II						2. Date of De Month	Da	y Y	ear	3. Time of Death
	/Medi Examir				street and number)			4b. City	Town, or	Location of		Septemb		. County of		3:45 A M
			Universi	ty Hospit	al			Bal	timo	re			В	altim	ore	City
	Funeral		5. Social Security N 217-70-5	lumber 6. Se	7. Age M 2 ☐ F	e (In yrs. la 46	ast birthday) Yrs.	If Unde Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Bir Month, Da 8/16/1	th LY,_Year)	9	. Birthpli Count	ace (State or Foreign ry) DC
	Director		Usual Residence of			40						8/16/1	958			DC
	nyland show	L	10a. State	10b. County		10c. City	, Town or Lo			-					10	d. Inside City Limits
	he Ma 8e-f s	Director	MD	Anne Aru	ndel		Pa	ısadeı								1 ☐ Yes 2X No
	with the or 2	D	10e. Street and Nu	mber scalon Ave	enile			10f. Zij	p Code	21122			10g. Cit	izen of Wha	at Count SA	ry?
	be filed within 72 hours after death with the Maryland that Hygiene. od other than "naturel", or Items 23a or 28e-f show od other than "naturel", or Items 23a or 28e-f show event. The Medical Examinar must be rediting at	Completed by Funeral	11. Marital Status		12. Was Decedent 8	Ever in U.S	3. 13.	Was Dece	dent of Hi			ecify Yes or No Rican, etc.)	)-	14. Race -	America	n Indian,
9	after or Ite	Fu		ied 2X Married	Armed Forces? 1 ☐ Yes 2X1 N If Yes, Give	No		If Yes, spe		n, Mexican, Specify:	Puerto	Rican, etc.)		Black,	White, e	tc.
21215-0036	hours turel',	q p	3 Widowed		Year or Dates:									Specify:		nite —————
15	in 72 n "nat	plete		15. Decedent's Ed	de completed)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa ork done d ise retired	ation during most	of work	ing	16b. K	ind of Busir	ess/Indi	ustry
212	filed withi Hygiene. other than ent, the M	mo	Elementary/Seco	12	College (1-4or 5	i+)		Mana						Gover	nmen	t
Maryland	be filed tal Hygid d other event.	Be		(First, Middle, Last)	1 -							e (First, Middle.		,		
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Ma	C				ancesca/wi	.fe						a <i>l R</i> oute <i>Numbe</i> adena Mi			te, Zip (	Code)
ore,	of Health item 27 other tr		20a. Method of Disp			20b. Pla	ace of Dispo metery, crei	sition (Na	me of	1		Date		cation - Cit	y or Tow	n, State
ij	mit. Pages bartment of i cortent: If ite		1 L⊈Burial 2 `4 □ Donation	☐ Other (Specify	Removal from State )	G1er	n Have	n Cer	neter	y				ı Burr	-	
Baltimore,	permit. Pages Department of t Importent: If ite any injury or or once.		21. Signal re of Fu	neral Servio Licen		01364	1	Seco	nd Addres	s of Facility 7e SW	Sin Gle	gleton n Burni	Fune e MD	ral H 2106	ome 1	P.A.
Е			23a. Part I. Enter the shock, or hea	ne disease, or comp rt failure. List only o	lications that caused one cause on each lin	the death.	Do not ent	er the mod	le of dying	g, such as c	ardiac c	or respiratory ar	rest,	-	í	Approximate nterval Between
£	Physician /Medical		Immediate Cause ( disease or condition resulting in death)	Final n			[njuri	.es							(	Onset and Death
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8760,	ate be executed hysician and the burial-transit	ical Ex	, , , , , , , , , , , , , , , , , , ,		Due to (or as a	a conseque	ence or):									
687	death certificate be executed e attending physician and of for use as the burial-transit	edic			d											
Вох	eath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent	progriatit	23c. If yes, outcome o			Ectopic pr					2	23d. Date of	delivery	
		slcia	in the past 12 1 Yes 2 0 9 Unknown		4☐Pregnant at			Other (sp					Ī	Month	D	ay Year
P.0	that the ded by the detached			icant conditions co	ntributing to death bu	it not result	ting in the ur	ndertvina c	ause cive	n in Part I	-	23a Did to	bacco u	se contribut	e to the	cause of death?
Vital Records,	requires that the reen signed by th hould be detache	d by										1 🗆 Y				oly 4 Unknown
000	> 0 0	plete										24a. Was a	an	24b. Were	autops	y findings available
Ä	The ate h page	Completed										autop perfor	sy med? 2 🗆 No	deat		Detion of cause of
Vita	Physicien: The this certificate h, ral director, page	Be	25. Was case referrexaminer?		Hospital:				Otha			(Check only or				
oţ	문 부 교	- To	1XXYes 2 ☐ 27. Manner of Death	140	1 ☐ Inpatier 28a. Date of Injun (Month, Day		R/Outpatien 28b. Time of		8c. Injury	r: 4 □ Nurs		ne 5 🗌 Resid			Specify)	
ion	Attending I r death. ector: After by the funer	atlor	1 Natural  2XXAccident	5 Pending investigation	9-14-04	Year)	7:12		8c. Injury Work' 1 □ Y	? es 2⊠No	C	perator of	mote	reycle	that	collidea
Division	I or Atten after deatl Director: in by the	ertification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju- building, etc.	ry - At horr . (Specify)	ne, farm, stre	et, factory	, office	3	2	WITH A V	treet and	Number of	Rural F	Route Number,
Ω	pitel ours af	0	00 0 00		Road							Koad	Lin	Wicke	J.M	0
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier (Check only one)	i∟ Certifying Phy 2∕∰Medical Exami	sician: To the best of ner: On the basis of and manner stat	examinatio	iedge, death on and/or inv	occurred restigation,	at the time in my opi	e, date and inion, death	place, a occurre	nd due to the c id at the time, d	ause(s) : late and	and manner place, and	as state due to th	ed. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier				29c	. License	number	_	2	9d. Date	signed (M	onth, Da	y, Year)
1	1/2		> hi	1 av.	m.5			C	.C.M	.E.		5	Septe	ember	17,	2004
3	1				ompleted cause of de					D-14	<b>.</b>					
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	Registr	-	S	EP 2 1 200	67	1		2000								

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)		1 - For State Registrar	State of Marylan		artment of Hea tificate of De		ntal Hygie	A 10 10 1	00000
Physic /Medi		1. Decedent's Name (First, Middle, Last	bonell 1	Beod	UN	2	Date of Death Month SEPTEMBE	Day Year	3. Time of Death 4 9:01a
Exami		4a. Facility Name (If not institution, give UNIVERSITY HOSPITA			4b. City, Town, or Loc BALTIMOF			4c. County of Dear	
Funeral Director		5. Social Security Number 6. Se 218-06-7075 Usual Residence of Decedent	x M 2□ F 7. Age (In yrs.	last birthday) Yrs.		Under 24 Hrs. 8 ours Min.	Date of Birth (Month, Day, Ye	9. Birn Co	thplace (State or Foreign byntry) ALYAN
laryland show	20	10a, State 10b. County	10c. Cit	ty, Town or Los					10d. Inside City Limits
ith the A or 28a-1	Director	10e. Street and Number	<i>\SAI</i>	timos	10f. Zip Code		10g.	Citizen of What Co	1) No 2 No nuntry?
death w	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. V	Vas Decedent of Hispan Yes, specify Cuban, M	nic Origin? (Specif	y Yes or No-	14. Race - Ame	rican Indian.
5-UUSO 72 hours after death with the Maryland natural', or Itama 23a or 28a-f show alsal Examilier invest be inclified at	by	1 X Never Married 2  Married 3  Widowed 4  Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		- 40	exican, Puerto Rio pecify:	ćan, etc.)	Black, White	
within 72 ho ene. then "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give I	ent's Usual Occupation kind of work done during O NOT use retired)	g most of working	166	o. Kind of Business/	Industry
land Z1	Be Con	17. Father's Name (First, Middle, Last)		Ca	shiere 18.	Mother's Name (F	First, Middle, Maid	11 000	essions
Vical Duld b Menta Arked arked	To	1ROY BROWN			U	esula.	Pohinson	2 Tim	nons
Mar d 2 sho d 2 sho th and 7 ls m traum		19a. Info ant's Name/Relationship (Ty	pe, Print) (morher	19b. Mailin	Address (Street and N	Number or Rural R	oute Number, Ci	ty or Town, State, Z	ip Code)
- c = 0 -			en limmers	3306				B, MARILA	
Pages '		20a. Method of Disposition  1 Burial 2 Cremation 3 F	temoval from State	emetery, crem	ition (Name of atory or other place)	9 Date	20c	. Location - City or	an /
Sallimore, sernit. Pages 1 a Department of Hee mportant: If itam iny injury or othe		' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service (scens)	1//	11. 616		1/25/0	4 11	m Sdex Jal	
Dalli permit. Departm Importa any inju		Mariado on C		RI	Name and Address of ANCY M. CA	UACLACE.	FEINERA	C Serecie	, es
Physician		23a. Part Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the death ne cause on each line.	n. Do not ente	r the mode of dying, suc	ch as cardiac or re	espiratory arrest,	MINKGIA	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	3,000	3			
	le.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					
be executed icien and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last							
	a		Due to (or as a consequ	uence of):					
certificate certificate oding physise as the	Medic		· <u> </u>						
death death e atter	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 1	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	very Day Year
law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the und	derlying cause given in F	Part I.	23e. Did tobacc	o use contribute to	the cause of death?
The lay the has age 2	Completed						24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
VICIAN: 1 Ician: 1 Certifica: ector, p	BeC	25. Was case referred to medical examiner?			26. F	Place of Death (C	1 Yes 2 ☐ I heck only one)	No 1 1 A Yes	2   No
Physician: rthis certific ral director,	은	XXYes 2 No	The state of the s	₹R/Outpatient	Oth			6 ☐Other (Speci	fy)
ding Phy th. After this	tlon:	27. Manner of Death  1 Natural 5 Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		Describe how in		7
I or Attending after death.  Diractor: After in by the fune	ifical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 秒 Hamicide determined	28e. Place of Injury - At ho	me, farm, street		28f.	Location (Street	wes shot	al Poute Number
oital or urs afte ral Dira	Certification	4 of Hollincide	building, etc. (Specify	Stri		Str	city or Town, Sta	timore m	N. Hilton
TO the Hospital or Attending Powithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	ledical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ▼ Medical Examin	ician: To the best of my know ler: On the basis of examinati and manner stated.	wledge, death o ion and/or inve	occurred at the time, dat stigation, in my opinion,	te and place, and , death occurred a	due to the cause It the time, date a	(s) and manner as s nd place, and due t	tated. o the cause(s)
with To 1	M	29b. Signature and title of certifier	m.d		29c. License numl	ber		Date signed (Month, CEMBER 17	
5		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type, Pr	street, Bal	timore,	Maryland	1 21201	
Sta		31. Date filed (Month, Day, Year)	32. Re serar's Signati	ure			-		
Registr	al	SEP 212	004 Menus	10. 14					

Registrar DHMH 17 Rev 1/2001 Keith Betters Unperki Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04 - 5865AKG 1 - For State Registrar Certificate of Death Reg. No. 29600 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Keith Betters 5:00 P M September 11, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA Baltimore 1323 Pentridge Road If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Feb. 18, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 108M 2□ F 38 217-92-0440 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or itams 23a or 28a-1 show ury or other traumatic event, I'm Medical Examinat must be indified at 1 ☑ Yes 2 ☐ No NA Completed by Funeral Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pentridge Roau

12. Was Decedent Ever in U.S. Armed Forces?

1 Married 1. Mar 21239 323 Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Black Specify: If Yes, Give Year or Dates: 1984 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roalwar 1246 Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bevery T. ANN Betters Lloyd Bastfield 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1708 E.33 PD St. Department of Health a Important: If Item 27 is any injury or other training once. BaHIMORE, MD Beverly A. Betters Muther 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9-16-04 Lansdowne ` 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 22. Name and Address of Facility
How, P-Close Formeral Sewice P.A.
709 Tessier St., Baltmine No 21201-1925 21. Signature of Funer I Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Methadone Intoxication Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease of hijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-transit Due to (or as a consequence of): the attending physician 68760 Physician/Medical use as Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? ģ 4☐Pregnant at time of death 5 Other (specify) P.O. 1 detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death.

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No Division of Vital Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' PENEUM 9 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at scene ¥XYes 2 No 28a. Date of Injury
(Mean, Day Year)

Payrol

28b. Time of Injury
Mo
Total

At home, farm, street, factory, office building, etc. (Specify) this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes XXNo death. Unknown 2 Accident Director: 6X Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide 1323 Pentridge Rd. Found at home 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Commonship of the date of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospital c within 24 hours af To the Funeral D completely filled in 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 12, 2004 O.C.M.E. Shell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYA WID - KORELL 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 2 1 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Yeer 19, 2004 Helen H. Bodine Sept. 4:00 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Cockeysville Broadmead Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Yrs. 213-03-8262 95 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r Items 23a or 28a-f show ther mast be notified at 1 ☐ Yes 2X No Cockeysville Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 York Road 21030 USA Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3K Widowed 4 □ Divorced "natural" it's Mudical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 N/AHomemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event QDCB. Benjamin W. Hazell Mary Agnes Hoffnagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Bodine/Son 565 Hold East Lake Road Tarpon Springs, FL 34688 20b. Place of Disposition (Name of 20a Method of Disposition Sept. 22, 20c. Location - City or Town, State Baltimore Washington 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD Crematory 21. Signature of Funeral Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Licens Michael J. Flagle 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons-cue Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? this certificate 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Unursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending Division 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

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30, Name and address of person who completed cause of death (Item 26a) (Type, Print)

Year)

SEP 2 1 2004

2. Registrar's Signature

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	_		Registrar  1. Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		ertificate of t	Jean	2. Date of De	Reg. No.	3. Time of Death
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and w		}	Usual Residence of Decedent  10a. State NRW 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
Aaryli f sho	878	5	NRW N/A		Lemgo					1. Yes 2 □ No
the 288-	THE COURT	Director	10e. Street and Number			10f. Zip Code		i i	10g. Citizen of What C	country?
death with the Maryland	4		Drechsler Strasse 9	)		32657			Germany	
death	9	Funeral		Was Decedent Ever in	1 U.S. 1	3. Was Decedent of Hi If Yes, specify Cuba	spanic Origin?	(Specify Yes or No		
after or its	SCHOOL SCHOOL		1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give		1 ☐ Yes 2 🗓 No	Specify:	sito riican, etc.,		hite
ING Z1Z13-UU30 be filed within 72 hours after death with the Marylan tal Hyglene. d other than "natural; or Itams 23a or 28a-1 ahow	Exe	d by	3 Widowed 4 Divorced	Year or Dates:						
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withir than	Ne N	Ę.	Elementary/Secondary (0-12) None	College (1-4or 5+)		one	,		N/A	
P Hyge	ř,	O	17. Father's Name (First, Middle, Last)		1 -		18. Mother's N	ame (First, Middle,		
		0	Peter Block				Nelly	Goossen		
larylan 2 should be and Mental is marked	traumatic	_	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Ma	ailing Address (Street	and Number or	Rural Route Numbe	er, City or Town, State,	Zip Code)
> ~ E ~ .	er tra		Peter Block			many, NRW	32657			
E TE	r other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☒ Re		p. Place of Dis cemetery, o	sposition (Name of rematory or other place	θ)	Date	20c. Location - City o	r Town, State
Pages ment of a	ury or		* 4 ☐ Donation 5 ☐ Other (Specify)		Wald Fr	riedhof	Unl	known	Elmgo, Ge	rmany NRW
baltimor permit. Pages Department of I	ny in		21. Signature of Juneral Service License	•	1	22. Name and Addres	s of Facility	tthews Fi	ineral Home	Tna
<b>1</b> 405	š 0		(8/milimum	9>					ineral Home indalk, MD	
			3a. art1. Enter le disease, or complic shock, or heart failure. List only one	ations that caused the decause on each line.	eath. Do not	enter the mode of dying	g, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
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riffica ng ph	ast	Med	IF FEMALE:				-			
DOX	or use	an/	23b. Was decedent pregnant in the past 12 months?	<ul><li>c. If yes, outcome of pre</li><li>1 ☐ Live birth 2 ☐ F</li></ul>	etal death	3 □Ectopic pregnancy			23d. Date of de Month	Day Year
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9 Phys	ret.	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time	of 28c. Injury	at		now injury occurred	- Solly)
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DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific	eldmo	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (Mon	th, Day, Year)
T W	8	_	I Fr				000			16,2004
	-		30. Name and address of person who con	poleted cause of death //	tem 23a) (Tue				- piconse	~ , , , , , ,
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	Sta	e.	HEN BRADY MD  31. Date filed (Month, Day Year) 2 1	200 (32. Registrar's Si	gnature #	Small s	UT TONE	7010 -1		
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			For State Registrar	State of Ma	aryland .			nt of He te of D			ental H	ygien Reg. N	0 0	011	700
	Physicia		Decedent's Name (First, Middle,  Joseph	East)		Bail	eV,	Sr.			2. Date of D Month	Death D	ay Year	3. Time	of Death
	/Medic Examin		4a. Facility Name (If not institution, guident Hosen Hosen)	give street and number)		Dati	4b. City	Town, or l		of Death			c. County of Death	1	
	Funeral Director		5. Social Security Number 6 213-32-7383 Usual Residence of Decedent	. Sex 7. Ag 1 ☑ M 2 ☐ F 7.	e (In yrs. last	t birthday) Yrs.	If Undo		If Under Hours	Min.	8. Date of B (Month, L) 7–15		r) 9. Birthp Coui	place (State ntry) Md.	e or Foreign
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	or 28	Olre	10e. Street and Number				10f. Z	ip Code				10g. C	itizen of What Cou	ntry?	
	ath w	ral	1408 Montpelier	<del></del>		1		2121					USA		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural, or Items 23e or 28e-f ehow other treumatic event, the Medical Examinations the notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 1 1 Yes 2 1 If Hes, Give Year or Dates:		•	Yes, sp	edent of His ecify Cuban 2 💢 No	panic Oi , Mexica Specify	in, Puerto I	cify Yes or N Rican, etc.)	10-	14. Race - Americ Black, White, Specify:		
21215-0036	within 72 ho ene. than "natur ha Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5		(Give life. l	kind of w DO NOT	ual Occupat ork done du use retired)	ion I <i>ri</i> ng mo	st of workin	ng		Kind of Business/In		
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Mai	d 2 sh th and 7 is n treun		19a. Informant's Name/Relationship Lucille Bailey	Wife			-						or Town, State, Zip altimore,		21218
	0 0 = =		20a. Method of Disposition 1 Burial 2 □ Cremation 3	Removal from State		e of Dispo etery, cren	sition (Na natory or	ame of other place	)	D	ate	20c. I	Location - City or To	own, State	V2411
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58760,	cate be executed /Medical Examiner sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or a)	a consequent a consequent	ew nce of): nce of):	the Cin		, bes		respiratory	arrest,		Approxim Interval 8 Onset an	letween
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Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other	-		(Check only				
of	g Physier this	tlon: To	1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju	iry 28	VOutpatien 3b. Time of Injury		28c. Injury	4 🗆 14	2	ne 5□Re 28d Describe		6 ☐Other (Specifury occurred	y)	
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	jury - At home c. (Specify)	e, farm, str	eet, facto	ry, office		2	28f. Location City or T		and Number or Rura te)	il Route No	imber,
	he Hospit n 24 hour ne Funere	edical (		Physician: To the best caminer: On the basis of and manner st	of examination										)(S)
)	To the To the Comp	W	29b. Signature and title of certifier	mil-	MI	7		C. License		146-	E6		ate signed (Month, tember, 1		
_	3		30. Name and address of person w	ol East Uni	versit-	1 Pars	Lww	y Bal	tim	ere, M	10 212	118	-2895		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 21	2004 32. egisti	rar's Signatur	K A	porte	,							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year Physician Clarice Bernice Blevins September 18, 2004 6:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2925 Goat Hill Road Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 □XF Director 1935 West Virginia 234**-**50-7012 69 Usual Residence of Deceden the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f ehow treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Items 23a 21015 2925 Goat Hill Road USA Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes & ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emmitt Angel Ova Barbara Pauley (nmn) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trei Gerald W. Blevins / Husband 2925 Goat Hill Rd., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donaylon 5 □ Other (Specify) 9-21-04 Bel Air Memorial Grdns. Bel Air, Maryland 21. Signature of Fungfull Service Licensee 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
10 month Immediate Cause (Final Meta static **Physician** en O Cerc disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. the attending physician IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? for Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. detached 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√2No 24a Was an autopsy 2 No certificate 1 Yes Hospitel or Attending Physicien: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Division 1 Natural death. 1 Yes 2 No 2 Accident investigation hours after deatlunerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funerel 6 29a. Certifier TAI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 1447 32. Registrar's Signat 31. Date filed (Month, Day, Year) State Registrar 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 10:15AM **Physician** SEPT 16 2004 LAURA Μ. CRAIG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs. HARBOR SIDE NURSING HOME 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Days **Funeral** Months Hours Min 1□M 21xF 67 Director 02/08/1937 VIRGINIA 228-50-8446 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show r then "natural", or Itama 23a or 28a-f shov the Medical Examiner must be notified at MYes 2 □ No Director BALTIMORE MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2770 FENWICK AVENUE 21218 USA by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED HOMEMAKER 9TH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **JAMES** WASHINGTON LOUELLEN MASON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2. ment of Health a lant: If item 27 If LAVERNE TAYLOR/DAUGHTER 1911 EAST 31ST STREET,

Oa. Method of Disposition (Name of cemetery, crematory or other place) other 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State ŏ permil. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 9/23/04 BALTIMORE, MD Funeral Service Licenses 22. Name and Address of Facility 21. Signat HOWELL FUNERAL HOME 21207 ler the disease, or complications that caused the heap failure. List only one cause on each life. 4600 LIBERTY HGTS AV. BALTIMORE MD e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Cause (Final De chine some so **Physician** /Medical Due to (or as a sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last hoe of) Examiner relian The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician sthe burial Box 68760. Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has t autopsy performed? 2 No certificate 1 Yes 2 1 No 1 TYes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide hours after 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 31464

State Registrar N

851

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician**  $P^{M}$ CRAIG 3:46 4a. Facility Name (If not institution, give street and number) SEPT 13 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL N/ABALTIMORE CITY If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1**∑X** 2□ F Director 75 02/14/1929 230-28-034 Usual Residence of Decede VIRGINIA Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Executivity mat be notified at BALTIMORE CITY 1 Yes 2 No N/AMD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 2770 FENWICK AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 2 3,∃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. Itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION self-EMPLOYED 9TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CRAWLEY LIZZIE 2 EDDIE CRAIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 EAST 31ST ST, BALTIMORE, MD 21218 LAVERNE TAYLOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of th
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any injury or of 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ZION CEMETERY 9/23/04 BALTIMORE, MD MT. 21. Signature of Fyneral Service Licer 22. Name and Address of Facility 21207 MD HOWELL FUNERAL HOME HGHTS AV, BALTIMORE, 4600 LIBERTY Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Cause (Final **Physician** Chronice disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** magnie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit en ceno and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year detached for Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 Yes 2 No 1 Yes 2 No Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Hom}\) Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 20104 ev. 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 82(N, FUTAN ST Soute 30P Back, MI 314M1 SHOAUS Day, Year)
1 2004 32. Registrar's Signature State Registrar

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CHARLCTTE CONNOR - SEPTEMBER 19, 2004 (@ 8:40 AM Division of Vital Records, P.O. Box 68760.

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State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** CATHERINE C735 AM CONRAD SEPT. 17 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BERUN WORCESTER 11003 GRAYS CORNER RD If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 79 Yrs. 217 26 2132 Director MARYLAND JAN ZI. 1925 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or Itams 23e or 28e-f show ent, the Wedical Evanciers must be notified at 1 Tyes 2 No Funeral Director WORCESTER MARYLAND BERLIN 10e. Street and Number 10f Zin Code 10g. 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Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1929 TRAPPE ROAD Apt F SON BAHMOR ONRAD DONALD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State of Cemetery Sept 21, 2004 BALTIMORE, MMY/AND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility ZANNING FUNCTAL Home 263 S. CONKLING ST. BALTIMORE MO 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fldenocorcinoma of The Physician disease or condition resulting in death) manths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2. No Month Day Year 4 Pregnant at time of death 5 Cther (specify) 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ crongry Natery Diseuse 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to edical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 2 ER/Outpatient 2 1 🗌 Yes 1 🔲 Inpatient 3 DOA this 28b. Time of Injury 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 500 800 Com ms 1)30619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter S POGETAMO Suitel Berlin Mcl 10445 Ocean Chy BIVd 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature Registrar SEP 2 1 2004

# DANGTHIS, JOHN

68760,
Вох
P.O.
Records,
Vital
of
Division

			Please 1					c. Ensure A	=		gible.	
			1 For State	State of Ma	aryland		ertificate of	Health and I	Mental Hy	2002 - 200		
			Registrar  1. Decedent's Name (First, Middle, Last	1		06	funcate of	Dealli	2. Date of De	Reg. No.		3. Time of Death
	Physici		John Anthony Da						Septem1	Day	Year 2004	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Death			inty of Deat	
T			Greater Baltimore		Cente	r	Towso			Ва	ltimor	ce
	Funeral		5. Social Security Number 6. Se 15	7. Age 7. Age	6 (In yrs. 1a 56	ast birthday Yrs.	Months Days		8. Date of Bit (Month, Da	31,48	Co	hplace (State or Foreign
	Director		Usual Residence of Decedent	7	50	113.			Jan.	31,48	Mar	yland
	nyland how		10a. State 10b. County		10c. City	, Town or I	ocation					10d. Inside City Limits
	8a-1s	Director	Maryland Baltimor	e		Luth	erville					1 ☐ Yes 2 ₹ No
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or itams 23a or 28a-f show ovent. The Medical Exaction must be notified at	Dire	10e. Street and Number				10f. Zip Code	002		10g. Citizen		ountry?
	eath	Funeral	8 Dodworth Court	12. Was Decedent I	Ever in U.S	S.   13		093 Hispanic Origin? (St	pecify Yes or No	USA		rican Indian,
0	or itan		1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 Tyes 2 1  If Yes, Give		.   10		Hispanic Origin? (S ban, Mexican, Puert	Rican, etc.)	14.	Black, White	e, etc.
215-0036	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:		Spe	ecify:	White
<u>ب</u>	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		16a. Dec	edent's Usual Occu e kind of work done	ipation e during most of work ed)	king	16b. Kind o	f Business/	Industry
	withir ene. than	omo	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Sale		Ba)		Whole	ماء	
Maryland 2	filed with Hygiene othar thai	Be Co	17. Father's Name (First, Middle, Last)	<b>-</b>		Date	Silicit I	18. Mother's Nam	ne (First, Middle			
<u>lan</u>	should be fund Mental Family Mental Family Mental Family Mental Men	To B	Anthony Danaitis					Olga Ma	tulonis			
ar Z	es 1 and 2 should b of Health and Ment f itam 27 is markad r othar traumatic e	•	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mai	ling Address (Stree	et and Number or Ru			wn, State, Z	Zip Code)
≥ (ĵ	and lealth m 27 har tr		Helen Johnson / Si	ster	205 8		St. Anne	Drive, S	treet,			
altimore,	Pages 1 nent of Ha int: If itan		20a. Method of Disposition 1	Removal from State	CE	emetery, cre	ematory`or other pla	· 1	Date			Town, State
	2 00 3		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. signature of Funeral Service Licens</li></ul>	99	Lou	don P	ark Cemet	tery 9/20	)/2004	Balti	more,	Maryland
B	permit. Depart import any inj once.		Kuhuk	Some	Jan.							e, inc. land 21229
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused	the death						TRAL y	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			11.	iver Dis	seaso				Onset and Death
	/Medical Examiner		resulting in death)				iver Dis					( 1010-1101)
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	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Alloho	1 1	once or):						40 years
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Box	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome	2 Fetal	death 3	Ectopic pregnanc	су			Date of deli Month	very Day Year
o.	that the de led by the a detached f	ystc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at 9☐Unknown	time of de	ath 5	Other (specify) _					
٦.	res that tigned by be detail	y Ph	Part II. Other significant conditions co	ntributing to death bi	ut not resu	Iting in the	underlying cause g	ven in Part I.	23e. Did t	tobacco use c	ontribute to	the cause of death?
rds	w requires been sign should be	ed by							1 🗆	Yes 2 No	3 □ Pro	obabiy 4 Unknown
O O	e faw re has bee	Completed							24a. Was		b. Were au	topsy findings available
ř		Com								ormed?	death?	completion of cause of 2 \subseteq No
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ot	Attanding Phyaician: r death. actor: Atter this certific by the tuneral director.	T.	1 ☐ Yes 2 ☑ No  27. Manner of Death	lospital:		28b. Time		her: 4 Nursing He	ome 5 ☐ Resi 28d. Describe			eify)
on	ding th. : Atter	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	Year)	Injury	Wo	ork? Yes 2 \ No	200. Describe	riow injury oca	curred	
Division of Vital Records,	l or Attano after death Diractor: In by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ary - At ho	me, farm, s	treet, factory, office	)	28f. Location (	Street and Nu	mber or Ru	ral Route Number,
á	tal or A s atter al Dira ed in by	Certification:	4 C Notificide	building, etc	э. (Зрөспу	<i>)</i>			City or To	wn, State)		
	To the Hospital or Attant within 24 hours atter death To tha Funaral Diractor: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami	sician: To the best oner: On the basis of	of my know examinati	vledge, dea ion and/or i	th occurred at the t	ime, date and place,	and due to the	cause(s) and	manner as	stated.
	thin 2, tha I mplet	Med	one) 29b. Signature and title of certifier	and manner sta	ited.			se number		29d. Date sig		
	¥ ¥ 8		Mymm M. Co	11111	010			56156		_		2004
	nXI		30. Name and address of person who co		eath (Item	23a) (Type	Drint\					
	3,,		Suzanne M. Cacco	100/02	6510	5 No	om Charl	les Stree	+ Balt	imore,	MO	21204
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure	Sports					
	Registi	ar	SEP ?	1 2004	Column .	, K	Mode	/				

Box 68760,	
, P.O.	
ital Records	
ion of Vi	

			State of Maryland / Depa		•	9
			1 - State Registrar Cel	tificate of Death	Reg.	NO 001 29712
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Lawrence R. Dec!cer			Day Year 3. Time of Death
	/Medic				Septembe	
	Examin	er	4a. Facility Name (If not institution, give street and number)  Singli Flospital of Baltimore	Baltimare Cit		4c. County of Death
<i>3</i> € <sub>7</sub>			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	*	Q Right place (State or Foreign
	Funeral Director		216-30-0300 1X M 2 F 70 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye April 1	9. Birthplace (State or Foreign Country)  1934 Md
	land ow		10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	Mary f she	TO.	Md Carroll Sykesvill	e		1 ☐ Yes 2 M No
	be filed within 72 hours after death with the Maryland ald Hygiene.  dial Hygiene.  dial Hygiene.  dial Hygiene.  event. If a Michical Exercities Frank be recitified at avent.	Director	10e. Street and Number 6602 Senecca Lane	10f. Zip Code 21784		Citizen of What Country?
	eath	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Sp.	1 1	14. Race - American Indian,
	ter d	Fun	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
2	urs al	þ	1 ☐ Never Married 2	1 ☐ Yes 2(☐ No Specify:		Specify: White
12-003b	2 ho	Completed	15. Decedent's Education 16a. Deced	dent's Usual Occupation	166	b. Kind of Business/Industry
<u> </u>	hin 7	pie	(Specify only highest grade completed) (Give life. If	kind of work done during most of work DO NOT use retired)	ng	lichting
N	ad wit	Con		sperson		lighting 
and		To Be (	17. Father's Name <i>(First, Middle, Last)</i> John Decker	18. Mother's Name Mary Rol	<i>(First, Middl</i> e, <i>Maid</i> Ner	den Sumame)
a Z	ges 1 and 2 should to f Health and Mer if item 27 is marke or other treumatic	_	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Rura	I Route Number, Ci	ty or Town, State, Zip Code)
Ma	l and 2 fealth a m 27 is her tre		Mrs. Betty J. Decker (spouse) 6602	Senecca Ln., Sykes	sville, Mo	1 21784
ē.	as 1 au of Hea item		20a. Method of Disposition 20b. Place of Dispo	sition (Name of natory or other place)	Date 20c	Location - City or Town, State
Ĕ	Page nent on int: if			y Cremation 9-22-	-04 Syl	kesville, Md
Baitimore	permit. Pages Department of H Importent: if ite eny injury or of		21. Signature of Funeral Service Licensee	Name and Address of Facility Had	ght Funer	ral Home & Chapel
	A		23a, Part1. Enter the disease, or complications that caused the death. Do not enter			Approximate
	Dhysisian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	- F1 600 6		Interval Between Onset and Death
•	Physician /Medical		disease or condition resulting in death)  a. Largorithic Vuin Due to (or as a consequence of):	ionary Fibrosis		
	Examiner					m e
	€	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	od ansit	Examiner	Cause (Disease or injury that initiated events			
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Q Q	certifica Iding ph	Physician/Medi	US SOLUTE			
ŏ	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delivery
D	that the death ad by the atter detached for u	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
5	at the	Phy	9 🗆 Onknown			
Ś	S C 0	by	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the cause of death?
cords	w require been significant	ted	Athal Fibrillation		1 L Yes	2 No 3 Probably 4 MUnknown
d)	law as b 2 s	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	ysicien: The faw is certificate has b director, page 2 s	Con			performed 1 ☐ Yes 2 ☑	death?
Vital	Attending Physicien: r death. sctor: After this certific by the funeral director.	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
010	Physic this ce al dire	ဂ္	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing Hor	ne 5 🗆 Residence	6 ☐ Other (Specify)
	ding Phy	:uo	27. Manyer of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	njury occurred
0	uttendi death. ctor: A y the fu	cati	2 Accident investigation	M 1 Yes 2 No		
DIVISION	irect irect	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	rei D	0				
	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place, a restigation, in my opinion, death occurred	and due to the cause ad at the time, date a	e(s) and manner as stated, and place, and due to the cause(s)
	the I	Medi	and manner stated.			
	To Too	<	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)	1-		Own Daconthe, Do	RES-000		nanber 18,2004
	り		30. Name and address of person who completed cause of death (Item 23a) (Type, Item 23a) (Ty	Print) 2401 Dital of Baltim	w. Belved Dre Bal	ere Ave . timore, Md 21215
8,	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
HE	Registr	ar	SEP 2 1 2004 Plane & A	novê y		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** September 16, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale If Under 1 Year If Under 24 Hrs. 8 grare Hospital Social Security Number 6. Sex (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 20 F 223 36 42 49 72 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23e or 28e-f show other treumatic event, the Medical Examinar munust be notified at 1 Yes 2 No Be Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/22/ U.S.A. BOX 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 □ Divorced Specify. Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then 'any injury or other treumatic event, the Medical process. Elementary/Secondary (0-12) College (1-4or 5+) School Jystem TEachER School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HAMIEHE AlBERT UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dant 3/81 BOX CIRCLE 21221 DMES 14 BAILMUNE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 104. Butmure MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Furreral Hime Vatuera 1129 N. CARILINE ST But BA HIMORE, Approximate Interval Between Onset and Death 3 Aug ( 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physicien and s the burial-transit Due to (or as a consequence of): P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 5 ☐ Other (specify) 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes

or Attending Physicien: The law requires that the death certificate be executed Certification: To within 24 hours after deat To the Funerel Director: in by

25. Was case referred to medical

280 No

5 Pending

investigation

6 Could not be determined

examiner?

27. Manger of Death

1 Natural

2 Accident

3 🗌 Suicide

(Check only one)

29a. Certifier

Medical

1 Tes

ormed? 2 No 1 Yes 26. Place of Death (Check only one)

Other:	4 Nursing H	lome	5 Residence	6 □Other (Specify)
Vork?		28d.	Describe how inj	ury occurred

28b. Time of 28c. in 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of ceptifier 005 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 npatient

Prive Baltimore

2 ER/Outpatient

3∏ DOA

State Registrar

		4	For State	State of Mary		artment of H		, ,	200	1. 20711.
			Registrar  1. Decedent's Name (First, Middle,	I act)		raneate or t	Jean -	2. Date of Dea	th	3. Time of Death
	Physicia		1/	1.1	-		-	Month	Day Y	fear
	/Medic		K143tal	-  		UNEVAL		Septen	1	
	Examin	er	4a. Facility Name (If not institution,	give street and number)	cailas	4b. City, Town, or	Location of Death	N.I.	4c. County of	
			The Johns T	TUDKINS MC	SPITAL	BUIT If Under 1 Year	1 MO / E	CHY		n/a
	Funeral			1□M 2√□E	n yns. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director	-	212-31-2596 Usual Residence of Decedent	14	110.			Aug. 5	,1990	Maryland
	and w		10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
	lanyl sho	ö		Baltimore			Essex			1 ☐ Yes 2∕XNo
	Ne N	Director	Maryland  10e. Street and Number	2023211020		10f, Zip Code			10g. Citizen of Wh	at Cauntar?
	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show int, I're Medical Examiner must be notified at	늅	123 Eastern Bl	vd.		TOT, ZIP CODE	21221		rog. Citizen of vvn	at Country?
	ath v	Funeral						7 1/ 1/	United	
	er de	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.
36	or l	by F	1 Never Married 2 Marrie	If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specify:	
21215-0036	ural		3 Widowed 4 Divorced	Year or Dates:						White
5	72 h	Completed	15. Decedent's (Specify only highest)	s Education grade completed)	(Giv	edent's Usual Occup be kind of work done	durina most of wor	king	16b. Kind of Busi	ness/Industry
2	within ene. than	du	Elementary/Secondary (0-12)	College (1-4or 5+)	///e.	DO NOT use retired	")		37 / B	
7	filed w Hygier other th	S	9 Years		S	tudent			N/A	
pu	tal H d oth	Be	17. Father's Name (First, Middle, L	unkn.					Maiden Sumame)	
<u> </u>	2 should be and Mental is marked of sumatic eve	၉					Sharo	n Duneva	ant 	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationsh	ip (Туре, Print)		ing Address (Street				
	Health Health tem 27 i		Debra Dunevan			Eastern I	Blva. Es	sex, Mai	ryrand .	21221
ore	of He		20a. Method of Disposition 1 □X8urial 2 □ Cremation		20b. Place of Disp cemetery, cre	osition (Name of amatory or other plac	ca)	Date	20c. Location - C	ity or Town, State
Ĕ	Page nent o int: ff	-	4 □ Donation 5 □ Other (Sp	ecify)	Holly Hi	11 Mem. G	dns. 9/17	7/2004	Middle	River, MD
Baltimore,	permit. Pages Department of h Important: if Ite any injury or of		21. Inature of Funeral Service L		PRINCIPLE TO A STATE OF THE PARTY OF THE PAR	22. Name and Addres			Dundalk	- Inc.
Ä	Depar Impo any ir		No. C.	Canl	1.	7922 Wise	Ave. Du	ndalk. M	arvland	21222
	и		23a Part1. Enter the disease, or o	complications that caused the						Approximate Interval Between
			shock, or heart failure. List of Immediate Cause (Final	only one cause on each line.		-				Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	JANI	1/4	$\rightarrow$	1		25 hours
	Examiner			Due to to as a c	onsequence of.		/ V /			
		P.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):	-	ATION ADD	BY COLA		
	nsit	Examiner	if any, leading to immediate name. Enter Incertying Cause (Disease or injury	4			APPR	BY OTCAL	118	
_6	cate be executed physician and the burial-transit	Xa	that initiated events resulting in death) Last	Due to (or as a c	consequence of):				- NAIMINA	2
8760,	cate be ex physician the buria	ā								
387	phys phys	dicai		0.						
9 ×	eath certific attending p for use as	/Me	IF FEMALE:	23c. If yes, outcome of	oregnancy				23d. Date	of deligence
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	□Ectopic pregnancy □ Other (specify)	1		Monti	
o.	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 <b>☑</b> Unknown	9□ Unknown	16 Or dealir 5					
٥.	hat ti od by detac		Part II. Other significant condition	ns contributing to death but r	not resulting in the	underlying cause div	en in Part I	23e. Did to	bacco use contrib	oute to the cause of death?
Records,	signe signe	by						1□Y	es 2 No 3	Probably 4 Unknown
orc	w requir been si should l	stec				-				
ec	e taw has b	ple						24a. Was a autop	sv pri	ere autopsy findings available or to completion of cause of
<u> </u>		Completed						perfor	med? de 2 <b>⊠</b> No 1E	ath? □Yes 2□No
Vital	Physician: The Is this certificate har ral director, page 2	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or	78)	
of V	nysle	은	1 X Yes 2 □ No	Hospital: 1 X Inpatient	2 ER/Outpatie	ent 3□ DOA Oth	er: 4 🗆 Nursing H	ome 5 🗆 Resid	ence 6 🗆 Other	(Specify)
0	ng PI ter th	ü	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time Injury		y at k?	28d. Describe h	ow injury occurred	i
Ō	Attending or death. ector; After by the fune	atic	2 Accident investig	jation September 8		- 14 17	Yes 2 No	PedestviA	n Struck	By car
Division	Atte	12	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		- At home, farm, s	treet, factory, office			treet and Number	or Rural Route Number,
ā	s after	Certification:		January, etc.,	Roadw	a4		100 Block		Blud FSEX MD
	Hospital or 44 hours afte Funeral Dir tely filled in	a	29a. Certifier 1 Certifyin	g Physicien: To the best of r Exeminer: On the basis of ex	my knowledge, dea	th occurred at the tir	me, date and place	, and due to the o	ause(s) and man	ner as stated.
	n 24 n 24 hs Fu	Medical	(ne) 2 medical c	and manner stated	d.	mvestigation, in my o	pinion, death occu	rred at the time, t	date and place, an	d due to the cause(s)
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Σ	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed	(Month, Day, Year)
			/ / / (			Res	000		Septemb	lev 9 7004
	0/		30. Name and address of person	who completed cause of dear	th (Item 23a) (Type	e, Print)			7,123	1, 200
	Y			1ckee, DO	600	N. WOIF	o St	Ballin	nove W	Norm, Day, Year) Nev 9, 2004  (D) 21287
	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's	s Signature	aut 2				
	Regist		SFP 2 1 2	004 Blown	St MA	B. C. C.				

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of Hertificate of L		nd Mental H	ygiene Reg. No.	nni.	00715
			<sup>2</sup> 1. Decedent's Name (First, Middle, I	Last)				22. Date of Month		Year	• 3. Time of Death
	Physici: /Medic	al .	Elva Lee DeSell					SEPTEN	MER 18	2004	8:37 P M
	Examin	CI	4a. Facility Name (If not institution, S SINAI HOSP		BALTIMORE	4b. City, Town, or			4c. Co	unty of Death	1
	Funeral				Age (In yrs. last birthday	If Under 1 Year	MORE If Under 2		Birth Wass	9. Birth	nplace (State or Foreign
	Director		213-18-6235	1 □ M 2 □ <b>X</b> F	84 Yrs.	Months Days	Hours	oct.	Birth Da <i>y, Year)</i> 3, 1919	Mary	land
	and	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Marylan -1 show ile 1 at	to	MD Baltimo	ore	Baltimore						1 □ Yes 2 🗷 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Cou	untry?
	eth wi		9102 Satyr Hil			21234			USA		
	ter de	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decede Amed Force d 1 Tyes 2	es?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origi In, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No- 14.	Race - Amer Black, White	
036	el', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 💢 No	Specify:		Sp	ecify:	white
5-0	within 72 hours atter deeth with the Maryland ene. than "naturel", or Items 23a or 28e-f show is Medical Exaira at must be codified at	eted	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occupa	during most	of working	16b. Kind	of Business/fr	ndustry
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4	Homen	DO NOT use retired laker	1)		Own H	ome	
	be filed tal Hygie d other	Be C	17. Father's Name (First, Middle, La	ast)	, nomen		18. Mother	s Name (First, Midd	lle, Maiden Su		
Maryland	ges 1 and 2 should be filed within 72 hours after deeth with the Maryla to f Health and Mental Hyglene. If item 27 Is marked other than "naturel", or items 23a or 28e-f show or other treumatic event, its Medical Exam and must be rediffied at	To	Benjamin Howard				Ruth	Gilber			
Mar	d 2 sh th and 7 Is m treum	ı I	Roy J. DeSell,			ling Address (Street a			nber, City or To 21601	own, State, Zi	ip Code)
	permit. Pages 1 and 2 Depertment of Health s Importent: If item 27 is any injury or other tre once.	1	20a. Method of Disposition		20b. Place of Disp	osition (Name of	-21	Date	1	ion - City or T	own, State
e E	Pages nent of int: If i		1 ABurial 2 □ Cremation 3  '4 □ Donation / □ Other (Spe		ate	ematory or other plac Cemetery		/23/04	Parky	ville,	MD
Baltimore,	permit. Depertin		21. Signature of Funery Service Lic	censee	2	22. Name and Address	ss of Facility			0 York	
0.1	20129		lea V	- Cluy		luck Towso				son, M	1D 21204
	W		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	nly one cause on eac	h line.	iter the mode of dyin	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician	1	disease or condition	u A	ortic stem	2120					tive years
	/Medical		resulting in death)	a	as a consequence of):						3
				Due to (or	as a consequence of): heumatic	fever					Fifty years
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Amend item # Type or Print in Black indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPT. 17, Day HAROLD DIINN 2004 9:20 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2502 LOLOA DRIVE KINGSVILLE HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1X M 2 ☐ F MARYLAND Yrs. 88 18,  $\tilde{1}$ 916 216-10-1452 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. HARFORD KINGSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2502 LOLOA DRIVE 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ves 2 No If ves, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH College (1-4or 5+) MAINTENANCE MECHANIC STANDARD OIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SARAH E. NASH LESLIE W. DUNN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2502 LOLOA DR., KINGSVILLE, MARYLAND 21087 ELIZABETH M. DUNN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) \$ACRED HEART OF JESUS 19/22/04 BALTIMORE, MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 21. Signature of Funeral Service Licensee ssee 23a. Part1 Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shockly or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter University and Cause (Disease or injury that initiated as our injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes XXYes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Pnysician /Medical Examiner The law requires that the death certificate be executed burial-transit physician and Division of Vital Records. P.O. Box 68760. the as attending use signed by the at d be detached fo

Physician/Medical by Completed page 2 s Be Certification: To funeral After after death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Director

Funeral

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in than "naturel", or items 23e or 28a-f show the Wedical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: if them 27 is marked other than "nature!" ~ ... any injury or other treumatic event.

the Maryland

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number City or Town, State)

Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

investigation

6 Could not be determined

29c. License number 038635 - 94 29d. Date signed (Month, Day, Year) 9-17-2004.

Name in address of person who complete: Lause of death (Item 23a) (Type, Print) PT- RD. FORT HOLIARD MD-21052

31. Date filed (Month, Day, Year) SEP 2 1 2004

2 Accident

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

DHMH 17 Rev 1/2001

To the Hospitel or Attending Physicien:

within 24 hours a

Medical

State

Registrar

dap			For Unpe	end Iter	State of 23a,pt	Marylai II,27	nd / Dep <b>per Jac</b>	artmen G836	t of H	lealth a	and M	lental Hy	giene	9		
			Registrar  1. Decedent's Name (i					rimout	COIL	Jean		2. Date of De	ath C	· UU+	3.	Time of Death
	Physici: /Medic		Deborah									SEPTEM	BER Da	14, 200	)4	3:58a <sup>™</sup>
	Examin	er	4a. Facility Name (If no			nber)				Location			4c.	. County of Dea	ıth	
5	Funeral		UNIVERSITY  5. Social Security Num	ber 6.	Sex .	7. Age (In yrs	. last birthday	If Under	1 Year	E CI	24 Hrs.	8. Date of Bir	th	9. Bir	thplace	(State or Foreign
3	Director		216-94-11	/0	1□M 2MF	3	4 Yrs.	Months	Days	Hours	Min.	(Month, Da Oct. 30	0.19		<sub>ountry)</sub> ylan	ıd
-4	land ow		Usual Residence of Di 10a. State 1	ecedent 0b. County		10c. C	ity, Town or L	ocation							10d. lr	nside City Limits
	Marylan 9-f show	tor	MD.	N/A		Ba	1timor	e							1	Yes 2 □ No
	or 28	Director	10e. Street and Numb	ər				10f. Zip	Code				10g. Cît	tizen of What C	ountry?	
	s 23s	rail	401 E. Eag	ger Str			10		202					ted Sta		
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23s or 28e-f show event, the Medical Examiner must be malified at	by Funerai	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4	, -	12. Was Dece Armed For 1 Tyes If Yes, Giv	ces? 2 No e	0.5. 13.	If Yes, spec	offy Cuba	ispanic Or in, Mexicai Specify:	n, Puerto	ecify Yes or No Rican, etc.)	)- 	14. Race - Ame Black, Whi	te, etc.	
21215-0036	'2 hour	ted b	1:	5. Decedent's f	Year or Da	ites:	16a. Dece	dent's Usua	al Occupa	ation			16b. K	and of Business		
215	rithin 7 ne. ner "n	Completed	Elementary/Second		rade completed) College (1	-4or 5+)	life.	kind of wo DO NOT u	se retired,	)	st of worki	ng				
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Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Mental M	To Be	James Elwe									irginia				
ary	ges 1 and 2 should t of Heaith and Men if Item 27 Is marke or other treumatic	-	19a. Informant's Nam				19b. Mail	ing Address						or Town, State,	Zip Code	e)
≥	1 and 1 ealth om 27 her tr		Mr. David		tz/ Brot									D. 2122		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tree once.		20a. Method of Dispos	Cremation 3	Removal from S	JIAIO	Place of Disp cemetery, cre			_	Sep.	20,		ocation - City or		
Ë	nit. Paratme cortani injury		`4 □Donation 5 21. Signature of Fune			,	en Hav	2. Name an	d Addres	s of Facili	2004			n Burni		
ä	permit. Departr Imports any inj		15	- Ha	LL	11607	56	rema	tion	n an	d Fi	ineral ires D	Al	ternat e. Bal	ive	s ore,MD.
	/Medical Examiner	Examiner	Immediate Cause (Fill disease or condition resulting in death)  Sequentially list cond if any, leading to immediate Cause (Disease or in that initiated events resulting in death) La.	nal itions, ediate ing ury	Due to (i	MINATE or as a conse	quence of):	TOCOC	COSIS	S					Ons	rval Between iet and Death
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P.O.	res that the de		Part II. Other significa	ant conditions	contributing to de	ath but not re	sulting in the	underlying c	ause give	en in Part I	l.	23e. Did t	obacco	use contribute to	o the cau	use of death?
rds	w requires been sign should be	ed by	ACQUIRED I	MMUNODE	EFICIENCY	SYNDR	ROME					1 🗆	Yes 2	□No 3□P	robably	4 Dunknown
Division of Vital Records,	Fhe law te has bage 2 s	Completed												prior to death?	utopsy fi complet	indings available ion of cause of
Vita	nding Physiclan: Th. th. : After this certifica s funeral director, p	Be	25. Was case referred examiner?		Hospitals	-			0,5		e of Death	(Check only o				
of	Phy r this	: To	1 X Yes 2 □ No 27. Manner of Death	)	28a. Date o	of Injury	₹R/Outpatie 28b. Time			4 1140		ne 5 Resi		6 □Other (Spe	ecify)	
ion	Attending in death.	atior	1 ☐Natural 2 ☐ Accident	5 Pending investigati	(Mont	h, Day Yeer)	Injury	м	8c. Injury Work 1 🔲 \	k? Yes 2□				,		
Divis	i i i i i	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 288. Place	of Injury - At I ng, etc. <i>(Spec</i>	home, farm, s	reet, factory	, office			28f. Location (. City or To		nd Number or R	ural Rou	ite Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 (Check only 2- one)	Certifying F	Physician: To the aminer: On the ba	isis of examin	nowledge, dea nation and/or in	th occurred rvestigation	at the tim	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s)	) and manner as d place, and due	s stated.	cause(s)
	To the within To the comp	M	29b. Signature and tit		i, mid			290	. License					te signed (Mont	-	
				1G LI	, m.D					Penn	Stre	et, Ba	Ltim	ore, Ma	ryla	ind 21201
	Sta Registi		31. Date filed (Month,	Day, Year) 1 2004	32. R	egistrar's Sign	natura /	par	2							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year Leoinel Kemp Ensor, Jr. 19 2004 Sept. 8:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14704 Thornton Mill Rd. Sparks Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral X** M 2□ F 218-32-3321 Yrs. Director 72 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28e-f shovedical Examinar must be notified at Completed by Funeral Director 1 Yes 2 No Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in ent of Health and Mental Hygiene.

nent of Health and Mental Hygiene.

nent of Health and Mental Hygiene.

The marked other than "natural", or ttems 23a or:

In yor other traumatic event, tirk Medical Expuriting must be. 14704 Thornton Mill Rd. 21152 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer 12 Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leoinel Kemp Ensor, Jr. Ruth Mildred Brown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lee Ensor/wife 14704 Thornton Mill Rd., Sparks, MD 21152 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 9/22/2004 1 X Buria∩ 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) Bosley United Meth. Ch. Cem. Sparks, MD Bryan W. Clary

Lemmon Funeral Home of Dulaney Valley, Inc.

10 W. Padonia Rd., Timonium, MD 21093

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 22. Name and Address of Facility Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARDIO Mu /Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Il-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 25 1 Yes Division of Vital To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home Hospital: 5 Specify) sidence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient r 1 🗌 Yes 3□ DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner Certification: Natural 5 Pending investigation s after dec. 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day Year) Signature and title of 30. Name and (Type, Print) istrar's Signatura 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State of Maryland	•	artment of F <i>tificate of</i>		ı wental H	/giene Reg. Ni	200i.	29710
		Negistrar     Necedent's Name (First, Middle, Last	)		imodio or	Dodin	2. Date of D	eath		3. Time of Deat
hysici: /Medic		Hilda Frances	Edwards				Sept.	18,	2004 Year	12:40 A
xamin		4a. Facility Name (If not institution, give			4b. City, Town, o		eath	40	c. County of Dea	ath
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Show	_	10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Lim 1 ☐ Yes 2 🔀
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ms 23	Funeral	1702 GHATMUCH RU	12. Was Decedent Ever in U.S	. 13. v	Was Decedent of I	lispanic Origin?	(Specify Yes or N		14. Race - Am	erican Indian,
Importent: If item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumatic event, it s Mudical Examination usib purnatified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	f Yes, specify Cub. 1 ☐ Yes 2 No	an, Mexican, Pu Specify:	ierto Rican, etc.)		Black, Whi	ite, etc. White
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arked atic ev	To B	Joseph R. Amatu				Elvir		chet:		
reum		19a. Informant's Name/Relationship (T)  George Edwards/h			-		Rural Route Numi	-		
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1: # 15 0 0' 0'		1 Burial 2 □ Cremation 3 □	Removal from State	metery, cren	natory or other pla				•	
injur)		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Livery			LIEY MEM . I. Name and Addre		. 09/22/2 Ruck Tol			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Laura mn 19 2004 September 6:00a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death West Friendship 2933 Summer Hill Drive Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 7 1985 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 XF 213-11-6286 18 Yrs Oct Md Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State Md 10d. Inside City Limits West Friendship Howard 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21794 2933 Summer Hill Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education 12 student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Perry Fath Claudia Fath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Perry Fath (father) 2933 Summer Hill Drive, West Friendship, Md 21794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mountain View Cem. Marriottsville, Md 9-23-04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Garde Harden Stenbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EWINGS Sarcoma Three years Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

**Physician** /Medical Examiner

attending physician and

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certificate

Physicien:

or Attending After

death.

Director

within 24 hours of To the Funerel

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

ral, or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent; if tiem 27 is marked other than "netural; or Item any injury or other treumatic event, the Middell Enemine

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

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burial-transit the cate has been signed page 2 should be det

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Classase or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed autopsy performed 1 ☐ Yes 2K No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 E No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 RNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

completely filled in by

29c. License number

D41444

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

September, 20, 1994

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Hospital; 600 North work steer, Baltimore MO Cohen MD 32 Registrar's Signature

31. Date filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Kenneth

SEP 2 1/2004

			For State Registrar	State of Man	yland .		artment <i>tificate</i>			and M	lental H	ygiene Reg. No.	OOL	2	9721
	Physicia	an	1. Decedent's Name (First, Middle, Last)								2. Date of D Month	eath Day	Ye		. Time of Death
	/Medic	al	Doroth		F	ishe		F	1		SEPTEM				7:45 PM
	Examin	er	4a. Facility Name (If not institution, give stre Saint Joseph Me		ente	217	4b. City, i	iown, or	Location o	WS0	n	4c.	County of D	eath ltim	ore
	Funeral		5. Social Security Number 6. Sex	7. Age (I	n yrs. last		If Under		If Under		8. Date of B	irth	9.	Birthplace	(State or Foreign
	Director		214-18-9424	1 2 <b>X</b> F	90	Yrs.	Months	Days	Hours	Min.	July 1	$\frac{7}{7}, \frac{19}{19}$	914	Mary	land
	and w		Usual Residence of Decedent  10a. State 10b. County	10	0c. City, T	own or Lo	cation							10d	Inside City Limits
	Maryl.	jo	Maryland Baltimore			Tow									1 □ Yes 2 □XNo
	r 28a	Directo	10e. Street and Number			10W.	10f. Zip	Code				10g. Citiz	zen of What	Country?	
	th with	ai D	20 Dunvale Road					2120	4				U.S.A		
	tems	Funerai		Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No	er in U.S.	13. \	Vas Decede f Yes, speci	ent of His fy Cubar	spanic Orig	gin? (Spe , Puerto	cify Yes or N Rican, etc.)	lo-	14. Race - A Black, W	mencan I	ndian,
2	rs afte	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ KNo If Yes, Give Year or Dates:			I□Yes 2	! <b>◯X</b> No	Specify:				Specify:	Whi	to.
3	2 hou ature		15. Decedent's Educat	tion	1	6a. Deced	ient's Usual	Occupa	tion			16b. Kir	nd of Busine		
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2	C1 c2 - 20		James N. Fisher	Son			Oak F				Linthi	-			21090
ָ כ	of Hez of Hez if Item or othe		20a. Method of Disposition 1		20b. Place	e of Dispo	sition (Nam	e of		**	ate		cation - City		· · · · · · · · · · · · · · · · · · ·
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2	endin sath. or: Af he fur	atic	2 Accident investigation	(		,,	М		es 2 🗆 N	10					
<u> </u>	or Att fter de direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home S <i>pecify)</i>	, farm, stre	et, factory,	office		2	8f. Location ( City or To	(Street and wn, State)	Number or	Rural Ro	ute Number,
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	To the To the Comp	Σ	29b. Signature and title of certifier	re Ala			29c.	License	number				signed (Mo		
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	10		30. Name and address of person who comp												
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	211 (	ISLER	DR	IVE,	_TOI	ASON,	MAR	YLANI	)_21;	204
	Registr	-	SEP 2 1 2004	32. Registrar's	א כ	A	and in	1							

		1	For State Registrar	State of Maryla		artment of Hertificate of L			iene	29722
			Negistrar     Necedent's Name (First, Middle, Las	st)				2. Date of Dear	th	3. Time of Death
	Physicia		Kenneth A	_	Sr.			Septembe	er 15, 2004	3:45 AM M
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or			4c. County of Death	1
	Examin	er	7420 Village Ro			Sykesvi	11e		Carrol1	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day	9. Birth	nplace (State or Foreign untry)
	Funeral Director		220-20-5115	XX 2□ F 76	Yrs.	Months Days	Hours Min.		7 09, 1928	
	D		Usual Residence of Decedent							10d. Inside City Limits
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	e Ma	5	MD Carro	11 2	ykesvil				0.00	
	라 다 0 r 2	Director	10e. Street and Number			10f. Zip Code			log. Citizen of What Co	untry?
	ath w	<u>ra</u>	7420 Village Ro		11.0	2178		acifu Vac or No.	United Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28e-f show amy injury or other treumatic event, the Medical Examiner must be maillised at ODGe.	by Funeral	11. Marital Status  1 □ Never Married ② Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1X Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2√√ No	Specify:	Rican, etc.)	Black, White	e, etc.
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Maryland	and has me	1	19a. Informant's Name/Relationship (						r, City or Town, State, Z	
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altimore,	Pages 1 nent of He ant: If Iten ury or oth		20a. Method of Disposition  1 ▼Burial 2 □ Cremation 3 □  1 □ Donation 5 □ Other (Special	Removal from State L	cemetery, cre oudon I	osition (Name of matory or other place Park Cemet	ery 09/	18/04	Baltimore,	Md. 21229
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ds,	signed det	d by						1 🗆 Y	′es 2□No 3 Pr	obably 4 Unknown
Ö	iaw requires as been sign 2 should be	Completed						24a. Was	an 24b. Were au	itopsy findings available
Rec	0 - 0	m							rmed? death?	completion of cause of
Vital Records,		e Co	25. Was case referred to medical				26. Place of Dear		2☑No 1□Yes	2 No
₹	5 6 6	o Be	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	0.0	/	dence 6 ☐ Other (Spe	cify)
of	Phys r this ral di	-	27. Manner of Death	28a. Date of Injury	28b. Time				now injury occurred	
on	Attending ir death. ector: After by the fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		K? Yes 2 □ No			
Division	Attendi death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could not	be 390 Place of Injury - A	t home, farm, s	treet, factory, office			Street and Number or Ru	ural Route Number,
Div	after Dire	Certification:	4  Homicide	building, etc. (Spe	ecity)			City or Tow	m, State)	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C		Physician: To the best of my luminer: On the basis of exam and manner stated.						
	ompl	Me	29b. Signature and little of certifier	W. K		29c. Licens	e number		29d Date signed (Mont	h, Day, (ear)
	7		> HALLED	Mull	<	1)	35 39	8	7-10	7
•	1/1		30. Name and It dress of person who	completed cause of death (I	tem 23a) (Type	e, Print)	× 11-1-1-1			
	10.		FloringKriter	555 Sout	n Car	iter Street	t Wastn	ninster	- MD 2115	57
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature					
	Regist		. QED 9 1 2	32. Registrar's Signal	1. 1	pode				
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ORIGINAL

IOI 1C	i W. Gr	am	ner 1 - Stata <b>Amend Item#</b> Registrar	State of Ma 1, Unpend	ryland <b>ten</b>	/Depa	artmen Tificat	t of Hea r me G e of De	Ith and M 835 9/2	ental Hy 7/04 t	giene as 🤈	004	<i>e</i>	9723
		24.4	Decedent's Name (First, Middle, Last							2. Date of De	ath			3. Time of Death
	Physici /Medic		Raymond W. G	rammer, Sr						Septem	ber .		04	07:15 AM.
1	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or Loc	ation of Death		4c.	County of D		
			St. Agnes HEALTHCA					timore					/a	
3	Funeral Director		216-28-7510	x 7. Age	71	st birthday) Yrs.	Months		Under 24 Hrs. ours Min.	8. Date of Bir (Month, Da July 2	ay, Year)		Country	ce (State or Foreign V) land
	land land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						100	d. Inside City Limits
	Marylan -f show fed at	ţ	Maryland Baltimo	ore		Ha	letho	orpe						1 □Yes 2√□No
	r 28a	Director	10e. Street and Number	1			10f. Zip					zen of What		
	th with	ai D	1152 Elm Road					21227			Ţ	Jnited	Sta	ates
	ams erms	by Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.		Was Dece	dent of Hispar	nic Origin? (Spe lexican, Puerto	ecify Yes or No Rican, etc.)	o- 1	14. Race - A Black, W		
36	or It	y Fu	1 Never Married 2 Married	1 □XYes 2 □ N If Yes, Give	0		1 🗆 Yes	•	pecify:			Specify:	rinto, ot	White
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show disal Examines must be molified at	q pe	3 XVidowed 4 Divorced  15. Decedent's Edu	Year or Dates:		16a Decer	dont's Heur	al Occupation					/ldi	-
7.	in 72 n "na fedic	olet	(Specify only highest grad	ie completed)		(Give	kind of wo	rk done durin	g most of worki	ng	IOD. KII	nd of Busine	ss/indu	stry
212	d within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Bus	Driv	er				Priva	te '	Trans.
	be filed tal Hygie d other avent,	Be C	17. Father's Name (First, Middle, Last)						Mother's Name					
<u>la</u>	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic avant, the M	10	Wilson Henry Gramm	ner					Lucy Ca	therin	e Coi	rrieri		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla at of Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23a or 28e-1 show or other treumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (T)						Number or Rura		-			,
	1 and Health am 27 other tr		Sharon L. Smith /	Daughter		5452 ce of Dispo			ve, Vir	ginia		a, Va.		
ية	Pages nent of t int: If its iry or of		1 ☐ Burial 2 Cremation 3 ☐ I		cen	netery, cren	natory or o	ther place)						iaryland
Baltimore,			<ul> <li>4 □ Donation 5 □ Other (Specify,</li> <li>21. Signature of Funeral Service Licens</li> </ul>		Bay	view (		nd Address of	9/23/					
Ba	permit. Departr Imports any inji		Sichard	and I	~	4	107 V	Vilkens	Avenue		imore			nd 21229
,	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition	lications that caused the cause on each lin Hypertens	θ.							ease	1	pproximate nterval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):								
Н		<u></u>	Sequentially list conditions,	b	conseque	ance of):							-	
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
Ć	exect an and rial-tra	Еха	resulting in death) Last	Due to (or as a	conseque	ence of):							-	
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dlcai		d										
9	intifica ing ph	Med	IF FEMALE:											
Box	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1☐Live birth	2 Fetal d	leath 3	Ectopic pi				2	3d. Date of Month		ay Year
	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of dea	ith 5∟	Other (sp	pecify)					_	
P.O.	that the death		Part II. Other significent conditions co	ntributing to death bu	it not result	ing in the u	nderlying o	ause given in	Part I.	23e. Did 1	obacco u	se contribute	to the	cause of death?
Records,	w requires that s been signed b should be deta	Completed by					_			1 🗆	Yes 2	X(No 3□	Probab	ly 4 □Unknown
00	> 0 70	olete								24a. Was		24b. Were	autops	y findings available
Ä	The lav ate has page 2	E								auto perfo	psy ormed? 2 \Begin{align*} \text{No}	prior death	to comp ?	y findings available letion of cause of
Vital	ystcian: This certificate director, pag	Be C	25. Was case referred to medical examiner?					26.	Place of Death				00 2	
of <	d is	2	1X Yes 2 □ No	Hospital: 1   Inpatier		R/Outpatien	ıt 3□ DC	OA Other: 4	I ☐ Nursing Hor	ne 5 Resi	dence 6	Other (S	pecity)	
on C	ding F	lon	27. Manner of Death 1 □ Vatural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury		28c. Injury at Work?		28d. Describe	how injury	occurred		
Division	Attending r death. actor: After	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	nr - At hom	ne farm etc	M /	1 [] Yes		28f. Location (	Street and	d Number or	Dural C	Pourto Alumbar
Ο̈́	after after Dira	Certification:	4 Homicide determined	building, etc	(Specify)	ie, iaiii, sti	eet, lactor	y, onice	1.	City or To	wn, State)	140mber of	nuidir	loute raumber,
	To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of iner: On the basis of	examinatio	ledge, death on and/or in	h occurred vestigation	at the time, da	ate and place, a n, death occurre	and due to the ed at the time,	cause(s)	and manner place, and o	as stat	ed. e cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner sta			290	c. License nun	mber		29d. Date	signed (Mo	onth, Da	y, Year)
	- × - ō		) Carmy H	allan	W	d		0.C.	MF					
	1/		30. Namerand address of person who co	ompleted cause of de		23a) <b>(T</b> ype,	Print)	0.0.	M.E.		ochr€	ember	17,	2004
_\	0,		L'AROL H	ALLAD	VW	- I	111 F	enn St	reet, p	1=1+i	-	Jan. 7	_ 5	21 201
**	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	2	bour	11		опттию	TE, I	ary 1a	DEL	21201
	Regist	al	SEP 2 1 2004	Alexander	/-	אן א	your	1						

9-17-2004 @ 71,25 p.m.

Division of Vital Records, P.O. Box 68760,

			ricase			R maemble mk.		-	•	
			1 - For Stete Registrar	State of Ma	arylano / i	Department of F Certificate of I		nental Hygle Reg.	2001	29721
ı	Physici		t, Decedent's Name (First, Middle, L	ast) Q	Gar	dner			Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g		<u> </u>		r Location of Death	Septembe	4c. County of Death	7. X3 P "
ı	Funeral			S HOSPI	e (In yṛs. last bi		IIUM If Under 24 Hrs.	8. Date of Birth	13altimo	re plece (State or Foreign
	Director	1	216 - 72 - 7987 Usual Residence of Decedent	1□M 2 <b>P</b> F	40	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	964 mai	rykan d
	//aryland f show	or	10a. State 10b. County  Baltin	nore	10c City, Tow	m or Location				10d. Inside City Limits
:	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If tiem 27 is marked other then "naturel", or items 23e or 28e-f show eny injury or other treumatic event, Ite Maulcal Examiner man be notified at once.	Funeral Director	10e. Street and Number		<u> </u>	10f. Zip Code			Citizen of What Cour	
:	death v ms 23e	erai	3410 Yataruk 11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Sp	US, ecify Yes or No-	14. Race - Americ	
0000	irs after il', or ite	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 104 If Yes, Give Year or Dates:		1 ☐ Yes 2 12 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	etc.
5	72 hou "nature	eted	15. Decedent's (Specify only highest g	Education	16a	Decedent's Usual Occup (Give kind of work done of	during most of work	ing 16b	Kind of Business/In	dustry
717	d within giene. er then if e M.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	CIERK	1)		Court	
	2 should be filed and Mental Hygi is marked other sumatic event, I	Be	17. Father's Name (First, Middle, Last Louis Gardner	1) Q			1	e (First, Middle, Maid	den Sumame)	
	2 should and Men is marke eumatic	2	19a. Informant's Name/Relationship	(Type, Print)	198	. Mailing Address (Street	LOUISE and Number or Pu	al Route Number, Cit	ty or Town, State, Zip	Code)
ב ני	1 and 1 Health tem 27		LOUISE Gardo	2r	20b. Place o	11 Sturgs f Disposition (Name of		Kesville,	MD 21  Location - City or To	208 own. State
	permit. Pages 1 a Department of Hes Importent: If item eny injury or othe once.		1  Burial 2 □ Cremation 3  1  Donation		King N	ry, crematory or other prod Nemorial Po	"K 9-2	4-04 RO	ndallotou	on, mo
Dall	permit. Departr Importe eny inju		21. Signature peneral Sarvio Li	net net	3	SALA FCO	March	Funers Pass B	al Homa	e PA. Dalaa9
L	μī	Г		mplications that caused y one cause on each lin	I the death. Do	not enter the mode of dyin	g, such as cardiac	or respiratory arrest,	0.110.7111	Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate @ause (Final disease or condition resulting in death)	a. LUNG	3 Car	of):				Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions,	b. Due to /or as	a consequence	ot).				
	scuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Officeas or frieny that initiated events	c						
00/	te be executed ysician and ie burial-transit	cai Ex	resulting in death) Last	Due to (or as a	a consequence	of):				
00 XO	ertificat ding phy se as th		IF FEMALE:	23c. If yes, outcome	of programmy					
	the death or the attenaction of	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	Day Year
cords, r	quires that en signed b tuld be deta	ρ	Part II. Other significant conditions	contributing to death bu	ut not resulting i	n the underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to the	1
יי ביי	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed						24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
NIG	ysicien s certifi director	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1  Inpatie	ınt 2□ER/Oı	tpatient 3☐ DOA Othe	ar.	h (Check only one) me 5 Residence	6 X Other (Specify	Arence
	nding Phy ath. r: After thi e funeral o	ation; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Injur (Month, Day	ry 28b.	Time of 28c. Injury	at	28d. Describe how in		персе
DIVISION	after des Directo	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, fa c. <i>(Specify)</i>	ırm, street, factory, office		28f. Location (Street City or Town, St.		l Route Number,
-	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one)  Certifying F  2 Medical Example	Physician: To the best of the basis of and manner sta	examination an	e, death occurred at the time d/or investigation, in my or	ne, date and place, pinion, death occurr	and due to the cause red at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
1	within To th compl	Me	29b. Signature and title of certifier			29c. License	number	29d. (	Date signed (Month, I	Day, Year)
4	`		30. Name and address of person wh	completed cause of de	eath (Item 23a)	(Type, Print) .	73725	7 -	20-201 10m MD	24
1	)			Nahmoo			Valley	d Timon	IUm MD	21093
	Sta Registr		SEP 2 1 20		. Signature	boots	•			

			For State Registrar		State o	f Marylar		artmen rtificate			and Me	ental Hy	- /		e E	29725
			1. Decedent's Name (First, Mid	dle, Last)				_				2. Date of D		av Vo		3. Time of Death
	Physici /Medio		Dianne Lee	Hybe	rg							Sept.	9,	2004	al .	11:00 a M
	Examir		4a. Facility Name (If not instituti	on, give s	treet and nu	mber)		4b. City,	Town, or	Location o	f Death		Reg. No.  Page N			
			4509 Woodfie	1d R	oad			Kε	nsin	gton				g. No. 2004  pay 2004  4c. County of De Montgo  Montgo  9. 8 6, 1946  g. Citizen of What County of De Montgo  14. Race - An Black, When Specify:  General Sumame  28 Murphy  City or Town, State, Con, MD 20  10. Location - City of Beltsvil.  Services  11. Services  12. Services  13. Services  14. Race - An Black, When Specify:  15. Murphy  16. County of Town, State, Con, MD 20  17. Con, MD 20  18. Con, MD 20  19.		
	Funeral		5. Social Security Number	6. Sex	м 2 <b>Д</b> F	7. Age (In yrs.		If Under Months	1 Year Days	If Under :	Min.		ay, Year			ice (State or Foreign y)
	Director		158-36-3782 Usual Residence of Decedent		W 227	57	Yrs.					Nov.	26,	1946	Ne	w Jersey
	end w		10a. State 10b. Coun	ty		10c. Ci	ty, Town or Lo	ocation							10	d. Inside City Limits
	f sho	ō	MD Mo	ntgo	merv	K	Kensing	ton								1 ☐Yes 2 ☐ No
	the 28a	Funeral Director	10e. Street and Jember					10f. Zip	Code				10g. C	itizen of What	Count	y?
	3a or		4509 Woodfiel	d Ro	ad				2089	5			1	Inited	S+-	tos
	ms 2	Jer	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Was Deced			gin? (Spec	ify Yes or Nican, etc.)		14. Race - A	merica	n Indian,
9	or its	F	1 ☐ Never Married 2 Ma	rned	Armed Fo 1 ☐ Yes If Yes, Gir	2 🗀 🗖 🗸		1 ☐ Yes 2		Specify:	, rueno n	ican, etc.)				
93	72 hours efter death with the Marylend natural', or items 23a or 28a-f show digal Examinat musi be redified at	d by	3 Widowed 4 Divorce	ed	Year or D	ates:		10 103 2	X	ороспу.				Specify.	whi	te
21215-0036	72 h 'natu	Completed	15. Decede (Specify only high				16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa rk done di	tion uring most	of working	9	16b. h	Kind of Busine	ss/Indu	ustry
121	vithin ne. han	ш	Elementary/Secondary (0-12)		College (	1-4or 5+)	Progr						(	Compute	r	Technolog
7	filed within Hygiene. ther than "		12 17. Father's Name (First, Middle	a. Last)			Trogr	am An			r's Name (	First, Middle				
and	ntal led o	Be c	Gerald LeRo		lpin										,	
Maryland	s 1 and 2 should be filed within 72 hours efter death with the Marylen I Health and Mental Hygtene. Item 27 Is marked other than "netural", or items 23a or 28a-f show other traumatic event, The Medical Examin or must be notified at	٦	19a. Informant's Name/Relation				19b. Mailir	ng Address	(Street a							Code)
Z	and 2 sealth ar n 27 is		Robert Hyberg,	hus	band		450	9 Woo	dfie	1d Ro	ad. I	Kensir	gtor	. MD 2	089	5
ē,	of Health item 27		20a. Method of Disposition				Place of Dispo	sition /Nan	ne of		Da		,			
Ę			1 ☐ Burial 2 Cremation  4 ☐ Donation 5 ☐ Other		emoval from	State	esapea				9/13	3/04	Ве	eltsvil	le,	MD
Baltimore,	그 분 뿐 글 .		21. Signature of Funeral Service		e //	1///	17 32	2. Name an	d Address	of Facility						
m	Depermine Deperm		Tami		TX	10/10	11 X 8	app F 33 Gi	uner	al an	d Cre	ematic	n Se	rvices	20	910
			29a. Part 1. Enter the disease, shock, or heart failure. Li	or compli	cations that of	caused the deat	h. Do not ent	er the mod	e of dying	, such as	cardiac or	respiratory	arrest,	6, 110	1	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition				ru Inc	ffi.o	iono	D	)1man	ow. E	'd om a			Onset and Death  months
	/Medical		resulting in death)		Due to	(or as a consec	juence of):		renc.	y — _	OTHOL	lary r	deme			
ш	Examiner		Sequentially list conditions,	ь		ltiple										7 years
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ł	Due to	(or as a conseq	uence of):								1	
	and and I-trans	каш	that initiated events resulting in death) Last	c		or as a conseq	uence of):								-	
8760,	The law requires that the death certificate be executed the bes been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	E E			20010	(0. 00 0 00.000	.,									
687	icate phys s the	dlcal													1	
	leath certifica attending ph I for use as ti	/We	IF FEMALE: 23b. Was decedent pregnant	2		come of pregna								23d. Date of	deliver	,
Вох	death atter	clar	in the past 12 months? 1 ☐ Yes 2 ☑ No		4 Pregr	oirth 2 Feta nant at time of c		]Ectopic pro ] Other (sp						Month	D	ay Year
o.	t the de by the a	Physician/Me	9 Unknown		9□ Unkn	own						1				
, P	res tha igned l be det	by P	Part II. Other significant condi							n in Part I.		23 <i>e</i> . Did	tobacco	use contribute	lo the	cause of death?
ğ	w require been sig should b	ed	Previous 1	Radia	ition '	Therapy	to Bra	ain fo	or		_	1 🗆	Yes 2	<b>X</b> No 3□	Probat	oly 4 □Unknown
of Vital Records,	law re es be 2 sho	Completed	Metas	tatio	Mela	noma						24a. Was		24b. Were	autops	y findings available
Ě	: The l	E O										perf	ormed?	death	?	
ita	sicien: certific irector,	Be (	25. Was case referred to medic examiner?						7		of Death (	Check only	оле)			
Ž	Physicien: this certific ral director,	ပု	1 ☐ Yes 2 📉 No				ER/Outpatier			4 1401					oecify)	
		on:	27. Manner of Death 1 XNatural 5 ☐ Pend		28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		8c. Injury Work	?		d. Describe	how inju	ry occurred		
Sic	Attending r death. ector: After by the fune	Icat	2 Accident inves	tigation d not be	29a Blace	of Injury - Al h	ome form str	M factors		es 2 🗆 N		If Location	(Street a	nd Number or	Rural I	Route Number
Division	를 를 를 드	Certification;	4 Homicide deter	mined	buildi	ng, etc. (Specil	y)	eer, ractory	, once		20	City or To	wn, State	e)	riurarr	TODIO INGINIDEI,
	Hospitel or 24 hours afte Funerel Dir stely filled in i		29a. Certifier 1 ☑ Certify	ing Phys	icien: To the	best of my kno	wledge, deati	h occurred a	at the time	a. date and	d place, an	d due to the	cause(s	and manner	as stat	ed.
	24 h	edical		I Examir	ner: On the b	asis of examina	tion and/or in	vestigation,	in my opi	nion, deat	h occurred	at the time	date an	d place, and d	ue to ti	ne cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certif	ier				29c	. License	number			29d. Da	te signed (Mo	nth, Da	ıy, Year)
)	1/		() M. 1.	1-1	and !	no			Ι	3261	0			Sept.	10,	2004
	14		30. Name and address of person	n who co	mpleted caus	se of death (Iter	n 23a) (Type,	Print)								
				omas		a 1021				Bet	hesda	, MD	208.	52		
	Sta Registr	_	31. Date filed (Month Par Yan	1 20	04 32.	egistrar's Signa	B 19	mele	•							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 2004 Sept. 13, 9:00 a м **Physician** Miller Humphrey Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda 5216 Marlyn Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 29, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number 319-30-5924 **Funeral** Days Hours 96 1 □ M 2 🔀 F 1908 North Carolina Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State items 23a or 28a-f show rer: 4st be notilied at Y☐ Yes 2 ☐ No Director Bethesda Montgomery MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number United States 20816 5216 Marlyn Drive Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. the Medical Examiner: 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: white 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 jo, XX Widowed 4 □ Divorced þ "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should ba file Department of Health and Mental Hy Important: If item 27 is markad oth any injury or othar traumatic event once. Be Mary Miller Andrew Falkener 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andrew Humphrey, Son P. 0. Box 186, 01d Chatham, New York

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location-20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Beltsville, MD 9/15/04 Chesapeake Crematory 5 Other (Specify) 4 Donation 21. Signature of Funeral Service Acepse 22. Name and Address of Facility Rapp Funeral and Cremation Services 20910 933 Gist Avenue, Silver Spring, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Early Underly Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Examiner The law requires that the death certificate be exacuted burial-tran attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown ō 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown ts baen signed by ti 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably X☐Unknown Completed 24a. Was an was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 XNo After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Natural 2 Accident 5 Pending 1 Tyes 2 No investigation death. within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sept. 14, 2004 D20367 Man nd address of person who completed cause of death (Item 23a) (Type, Print) 30. Name Dr. Joel Kalman, 6111 Executive Blvd., Rockville, MD 20852 Registrar's Signat 31. Pate filed (Month, Day, Year) State SEP 2 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMEND ITEM #8 PER FH C835 9/24 CHICAGO OF Death 3. Time of Death 2 Date of Death Month Day Year **Physician** Donald James Harris 09 17 2004 1:23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 189 10th Street Pasadena
If Under 1 Year If Under 24 Hrs. Anne Arundel

8. Date of Birth 03/27/1938 holace (State or Foreign (Month, Day, Teal) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months 1 M 2 □ F 66 Yrs. Elkins Director 216-36-4916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Pasadena MD Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō USA or Items 23a 21122 189 10th Street Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No b Specify. 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) ocal 70 Street Light Tech Electric 10 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event. It 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hattie Grace Gibson James Bernard Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 189 10th Street, Pasadena, MD 21122 Catherine Harris - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 9/20/04 Glen Burnie, MD Glen Haven Cemetary 22. Name and Address of Facility Stallings Funeral Home, 21. Signature of Funeral Service Licens Duce 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the threase, or complication in that caused shock, or heart fail are. List only one cause on each lip le death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition cancer Physician O Months /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 **N**O 5 Pasidence 6 □Other (Specify) Medical Certification; To 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier D 39505 nd address of person who completed cause of death (Item 23a) (Type, Prill) br. Glen Burnie MD. 21061 hish Markan 305 HUSDI tall br. Glen Burnie MD. 21061

Registrar

State

31. Date filed (Month, Day, Year)

SEP 2 1 2004

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3: Time of Death Day **Physician** Theresa Marie Houck September 17 2004 3:20 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Corsica Hills Nursing Home Centerville Queen Annes | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 22, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□xF 218-05-1234 89 Yrs. Maryland **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat, or items 23s or 28e-f show any fujury or other traumatic event, the Marical Exemitient interinal be notified at once. 1 Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7740 Baltimore Annapolis Blvd. 21061 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Restaurant Cook / Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be " unknown " John L. Kroener 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gary Houck / son 1800 Drylie Court, Virginia Beach, Virginia 23464 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 09/21/2004 | Glen Burnie, MD 22 Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licenses me 0 1 Second Avenue S.W., Glen Burnie, MD 21061 1 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Premoria **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute. Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ţō Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 2 10 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No Other: Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending death. М 2 Accident investigation 1 ☐ Yes 2 ☐ No after death the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospitel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D32034 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Drue Chistory Mis 216 2108 Durch

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

P.O. Box 68760

Division of Vital Records,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year CECELIA 220 AM HORN SEPTEMBER 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MARYLAND MUSSICHL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | March 13, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕶 F 535-18-8701 82 Oregon Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinationst be confined at 1 ☐ Yes 2 No Directo Marvland Prince George Laurel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1207 Whiteway 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 ģ Specify 3 ₩idowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F pp Pages 1 and 2 should be ment of Health and Menta tant: If item 27 is marked Andrew Fischer Eva Richter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Horn 4030 Larkspring Row, Ellicott City, Maryland 21042 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o important: if any injury or once. ŏ St. Mary's Church Cem. 9/23/2004 Laurel, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funetal Service Dansee 22. Name and Address of Facility
Fleck Funeral Home, Inc. MO1250 7601 Sandy Spring Road, Laurel, Maryland 20/0/ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATOBILIARY CARCINOMA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Examiner death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician by Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 No 1 Yes of Vital Be director 25. Was case referred to medical 26. Place of Death (Check only one) examine Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After Division or Attending 1 Natural 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide To the Hospital within 24 hours all To the Funeral D completely filled it pelli Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SEPTEMBER 20, 2004 RESCOO HEDICH RESIDENT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GROWE STREET BALTIMONE, MO 21201 RICHARD WOOD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Eleve It Anoth Registrar

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			for State	State of Marylan			of Health a	and Mental			
			Registrar  1. Decedent's Name (First, Middle, La	act)	Cer	lincale	or Death	2 Date	Reg. of Death	No.	29730
	Physicia	an	****	·				Mont	h	Day Year	6.4
	/Medic		4a. Facility Name (If not institution, give	SEPH HORN	<u>,                                     </u>	4h City Tou	m, or Location of		EMBER		04 8:30 P <sup>™</sup>
	Examin	er	MARINER HEALTH CA		TAUDET	,		or Death		4c. County of De	
-				Sex 7. Age (In yrs.		LAUREI		24 Hrs. 8. Date		PRINCE G	
	Funeral Director			1 3km 2 □ F 88	Yrs.	Months Da	ays Hours		h, Day, Ye	1016	irthplece (State or Foreign Country) MISSOURI
			Usual Residence of Decedent					AI KIL	21,	1710	MISSOURI
	ylan		10a. State 10b. County		ty, Town or Lo	cation					10d. Inside City Limits
	a-f a	cto	MD PRINCE G	EORGES LAUR	EL						1 X Yes 2 ☐ No
	th the	)re	10e. Street and Number			10f. Zip Cod	de		10g.	Citizen of What C	Country?
	23a	Funeral Director	1207 WHITEWAY			20	707			U.S.A	
	ems erms	inel	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent	of Hispanic Orig	gin? (Specify Yes	or No-	14. Race - Arr Black, Wh	
9	or it	五	1 Never Married 2 Married	1 XYes 2 No If Yes, Give			No Specify:	, , , , , , , , , , , , , , , , , , , ,	,	Specify:	nto, 6tc.
	be filed within 72 hours after death with the Maryland and Hygiene. A clear \$28 or 28s-f show do then than "natural", or flems \$28 or 28s-f show event, the Madical Examinating the notified at	d by	3 Widowed 4 Divorced	Year or Dates:						WE	HITE
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Maryland 21215-0036	2 should be filed and Mental Hygis is marked other aumatic event, I	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	na Address (Str		er or Rural Route N	lumber Cii	tv or Town State	Zin Code)
2	s 1 and 2 should of Heelth and Men Item 27 is marke other traumatic		DAVID HORN/SON	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							ZLAND 21042
e e	Heelth tem 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name o	1	Date		. Location - City o	
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Вох	leath certific attending p	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregna	ancy			23d. Date of de	elivery
m	deat	sicie	in the past 12 months?  1 Yes 2 No	4 □ Pregnant at time of d		Other (specify				Month	Day Year
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	w requires that been signed to should be deta	by F	Part II. Other significant conditions ANEMIA	contributing to death but not res	ulting in the ur	nderlying cause	given in Part I.	23e.	Did tobacc	o use contribute	to the cause of death?
g	en si	ed	ANDITIA						1 🗌 Yes	2 No 3 F	Probably 4 DUnknown
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Ě	The tate has page	Completed		OCYTIC LEUKEMIA	1				performed es 2 💢	? death?	
Division of Vital Records,	ician: Th certificate rector, pag	Bec	25. Was case referred to medical				26. Place	of Death (Check of			
>	d Si	ToE	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ER/Outpatien	t 3 DOA	Other: 4 XNur	rsing Home 5	Residence	6 ☐Other (Spe	ecify)
0	ding Ph h. Atter th funeral		27. Manner of Death  132 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. l	njury at Work?			ijury occurred	
0	tendir Jeath. tor: Al the tu	Certification;	2 Accident investigation	on			1 ☐ Yes 2 ☐ N	No			
Ž	after deati	ţį.	3 Suicide 6 Could not be determined		ome, farm, stre	eet, factory, off	ice		ion (Street r Town, St		Rural Route Number,
	itet c urs af ral D										
	Hosp 4 hou Fundi	edicai	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina	wledge, death	occurred at the	e time, date and	d place, and due to	the cause	(s) and manner a	s stated.
	To the Hospitet or A within 24 hours after To the Funeral Direction Completely filled in b	Med	one)	and manner stated.							
	To To		29b. Signature and title of certifier	10 10			ense number			Date signed (Mon	
7			1.ur	900			24997		SEF	TEMBER 1	17, 2004
	10+1		30. Name and address of person who LUIS A. CASAS, N			,	IDET NO	20707			
	-0		31. Date filed (Month, Day, Year)	32. Registrar's Sigoa			JREL, MI	20/0/			
	Sta	ne	SEP Z 1 / W		ture	120					

			1 - For State Registrar	State of Mary		artment of I		d Mental Hygie	ene	20721
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		Josephine Hannem 4a. Facility Name (If not institution, give si			4b. City, Town,	or Location of D	Septembe	er 17, 200 4c. County of Deat	74
	LAdillii	CI	Genesis Eldercare	Cromwell		Parkvi	lle		Baltimo	
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day, Y. 8/22/191	ear) 9. Birti	hplace (State or Foreign untry)
	Director		219-42-0683 Usual Residence of Decedent		93 118.			8/22/191	.l Mar	yland
	72 hours after death with the Maryland natural', or ttems 23a or 28a-f ehow ilout Examinar must be notitled at	_	MD 10b. County	10	c. City, Town or Li Baltimo:					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	ecto	10e. Street and Number		Daitimo.	10f. Zip Code	-	100	. Citizen of What Co	
	3a or	DI	4230 Belmar Avenu	e			1206		U.S.A.	unity:
	ems 2	Funeral Director	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of	Hispanic Origin'	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No		,		hite
21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene d other than "natural", or Items 23s or 28s-f show event, the Madicul Examination at collified at	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occu	pation	16	b. Kind of Business/	Industry
218	within 7 ene. than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)			
42	e filed within al Hygiene. other than '		17. Father's Name (First, Middle, Last)		Homer	naker	18. Mother's	Name (First, Middle, Ma.	wn Home	
lan	should be nd Mental marked o	To Be	Casmir Przyglski					nia Jaroszew		
Maryland	s 1 and 2 should it Health and Men item 27 is marke other traumatic.		19a. Informant's Name/Relationship (Typ	oe, Print)				r Rural Route Number, C		
	s 1 and of Health item 27 other tr		William Hanneman  20a. Method of Disposition					Baltimore, M	laryland 2	
nor	Pages nent of hant: If ite		1 ☐ Surial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Ob. Place of Dispo cemetery, cre	matory or other pla i Cemetei			ltimore,	
Baltimore,	+ tt.	1	21. Signature of Funeral Service License	9			- 1	Miller-Dippe		
ä	Depa Impo any i		16/15					l Baltimore,		
STATE OF STA	Pnysician /Medical Examiner	ıer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Law leaving to make the conditions and the conditions are conditions.	e cause on each line		-	-	ehay _		Approximate Interval Between Onset and Death  August Augus
68760,	tilicate be executed ig physician and as the burial-transit	fedical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):					
P.O. Box	The law requires that the death certifics the has been signed by the attending pt page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify)	су		23d. Date of deli Month	very Day Year
	w requires that been signed b should be det:	by	Part II. Other significant conditions con  End Stage	tributing to death but no	1 -	underlying cause g	iven in Part I.			the cause of death?
Vital Records,		Completed	0					24a. Was an autopsy performer	prior to d	topsy findings available completion of cause of 2 No
Vita	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner?	ospital:	• C 5010 · · ·		. 1000	Death (Check only one)		
ō	ttending Physideath. ctor: After this y the funeral di	1-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time of Injury	of 28c. Inju	4 Nursir	ng Home 5 TResidence 28d. Describe how		ify)
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)			City or Town, S		
	Hosp 24 hou Fune stely lil	edical	29a. Certifier (Check only one)  Certifying Phys  2 Medicel Exemin	ier: On the basis of exa	amination and/or in	ivestigation, in my	opinion, death of	lace, and due to the caus occurred at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	( - A -	20	29c. Licer	se number	29d.	Date signed (Month	n, Day, Year)
			> Griffen	Gao, n	11/	Deo	59855	- Sep	ot, 20,	2004
	0		30. Name and address of person who con	mpleted cause of death	(Item 23a) (Type	Print)			21.20	Qinglin GAZ
	Sta	ite	360 Loch Rave 31. Date filed (Month, Day, Year)	32. Rajistrar's	Signature, 2	Dathmo	re, n	aryland	X1257 (	Arrigine 4/10
	Regist		31. Date filed (Month, Day, Year) SEP 2 1 20	104 Hiller	J. J.	Contract of the Contract of th				

				State of Maryla  For State Registrar	nd / Depa		lealth and M	ental Hygie	-	20720
				Decedent's Name (First, Middle, Last)				2. Date of Death	- U U H	3. Time of Death
		Physici		David Klah	r	Hatz	Ė	eptembei	$^{\text{Day}}_{17}$ , $2\overset{\text{Year}}{004}$	1:15 P M
		/Medio Examir		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Death	1.13
	4	LAGIIII	IGI	Gilchrist Center		Towson			Baltimo	re
		Funeral			. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		
		Director		210-14-3017 1M 2 F 79 Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	Sept. 16	, 1925 P	place (State or Foreign atry)
		within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23e or 28e-1 ehow he Medical Examiner riust be notified at		10a. State 10b. County 10c. C	ity, Town or Lo	cation		· · · · · · · · · · · · · · · · · · ·	1	0d. Inside City Limits
		Mary	ō	MD Baltimore L	uthervi	110				1 ☐ Yes 2 🗷 No
		28a	eC.	10e. Street and Number	a cuer vi	10f. Zip Code		100	. Citizen of What Cour	ntru?
		with	Funeral Director	155 Othoridge Road		2109	2		Inited Stat	The state of the s
		98th	gra		11.0					
		er de item	Ľ,	Armed Forces?	WII	If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F	Rican, etc.)	14. Race - Americ Black, White,	
	36	s aft	by F	1 □ Never Married 2 □ Married 1 X ☐ Yes 2 □ No U If Yes, Give Year or Dates:		1 ☐ Yes 2XX No	Specify:		Specify:	hite
	8	hour lurai	D T		160 Door	dest's House Ossus	-tion	14	Ye Kind of Davis and B	4
	7,	"na"	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done of the contract of the contr	ation during most of working	g	6b. Kind of Business/Ind	dustry
	12	within	g	Elementary/Secondary (0-12) College (1-4or 5+)		esigner	2)		70.40	1 m
	2	led y		17. Father's Name (First, Middle, Last)		caryier	18. Mother's Name	(First Middle Ma	Jewe	TTY
	Ĕ	be find he find he find of other	Be	Ralph B. Hatz					iden Sumame/	
	<u>×</u>	Mer Merke	၉		_		Mabel	Klahr		
	Maryland 21215-0036	12 should be filed within h and Mental Hygiene. 7 ie marked other than " traumatic event, tha Mas		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zip	Code)
Z	2	and Balth n 27		Karen L. Lumpkin/Daughter			ill Road,			·
ski	or e	of H of H riter		· □ · · · · □ · · · · · · · · · · · · ·	cemetery, crer	sition (Name of matory or other place	ce) <sup> </sup>		c. Location - City or To	
= 1	Ĕ	Pag nent int: i		`4 □Donayon 5 □Other (Specify)	rdens o	if Faith (	Lemetery U		Parkvill	
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Wadical Examiner; unit by nuffled at once.		21. Signature of Fureral Service Libertone  S. Coster, M					Funeral H vland 212	
ナ				23a. Parl . En -r the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	ath. Do not ent	er the mode of dyin	ng, such as cardiac or	respiratory arres	i,	Approximate
200				Immediate Cause (Final	7					Interval Between Onset and Death
3		Physician /Medical		disease or condition resulting in death)		rounte	cancer			years
.0		Examiner		Due to (or as a conse	equence of): 🔭					1
ber 1%	100		<u></u>	Sequentiatly list conditions, if any, leading to immediate Due to (or as a conse	variance of):					
H		sit s	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.	quence oi).					
to.		ecut and tran	Examiner	that initiated events resulting in death) Last  C	auguana ath					
3	0,	e be exe /sicien ar e burial-t		resulting in death) Last Due to (or as a conse	iquence or):					
	68760,	ate b hysic he b	lical	d						
2	99	certifical Iding phy Ise as th	Jed	IE ECMALE.					-	
7	Вох	uires that the death certificate be executed signed by the attending physicien and d be detached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy	,		23d. Date of delive	*
5		death e atten	Cla	in the past 12 months?  4 Pregnant at time of		Other (specify)			Month	Day Year
2	0	the by th	hys	9 ☐ Unknown						
S	<u>or</u>	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
	g	uires la sign						1 ☐ Yes	2 No 3 Prob	ably 4 Dunknown
	Records,		Completed					24a. Was an	24h Wara auto	nev findings qualishin
N	š	The law ite has b	m					autopsy performe	prior to cor death?	psy findings available apletion of cause of
12	<u>E</u>	: Th	Ö					1□ Yes 25	20No 1 ☐ Yes	2 No
4	Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?		0.1	26. Place of Death	(Check only one)		
+	of	hysi his c	2		☐ ER/Outpatier	at 3 DOA Oth	er: 4 Nursing Hom	e 5 Residen	ce 6 Kill ther (Specify	, haipip
		ng P fter t nera	:uc	27. Manner of Death 1 ☑Ratural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	f 28c. Injur Wor	y at 2 k?	3d. Describe how	injury occurred	
$\bigcirc$	.0	Attending r death. ector: After by the fune	ati	2 Accident investigation		M 1 🗆	Yes 2 □ No			
/_	Division	er de rectu	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office	2	Bf. Location (Stree City or Town,	et and Number or Rura State)	l Route Number,
>	Ö	s aft	Certification;						,	
DAVID		To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Check and C	nowledge, deatl	h occurred at the tin	ne, date and place, a	nd due to the cau	se(s) and manner as st	ated.
		ne Ho ne Fu ne Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	iation and/or in	vestigation, in my o	pinion, death occurre	a at the time, date	and place, and due to	the cause(s)
١		Nithiu Fo th	ž	29b. Signature and title of certifier		29c. Licens			. Date signed (Month, I	
4			1	MACCANO		D	58303	S	entember	172004
		-/:1		30. Name and address of person who completed cause of death (Ite	m 23a) (Tune	Print) .				
		5 th		Main all address of person who complete cause of death (in	2 /	Lorles 1	+ Balto	ndo 1	estember 10 21 201	4
	15	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature		. ,,.			/
		Regist		SEP 2 1 2004 Been	H A	and a				
			\$	OLI ATE CUUT LACETAL	No. Lin	ASSESSED OF THE PARTY OF THE PA				_

			-	For Stete	State of	f Maryland	•	rtment of F	lealth and M Death		giene Reg. No. () () (	20722
				Registrar  1. Decedent's Name (First, Mid	idle Last)			meate or	Death	2. Date of Dea		3. Time of Death
		Physicia			SYLVIA	LEE	6-1	ERNDO	1	Month	Day Yeer 16, 2004	9:40 P. M
4		/Medic		4a. Facility Name (If not institut					r Location of Death	Ser	4c. County of Dear	th •
•		Examin	er	Gilchrist	Cent				cusoN		BAIT	Imore
		Funeral		5. Social Security Number		7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl (Month, Day		hplace (State or Foreign
		Director		231-32-6118	1□M 2XF	83	Yrs.	Months Days	Hours Min.	April 2		RGINIA
		2		Usual Residence of Decedent								J
		arylen show	_	10a. State 10b. Cour	ıty		Town or Loc					10d. Inside City Limits  1∕⊠Yes 2 □ No
J.		e Ma	cto	MARYLAND		13,	2/11	7				16
ũ	٤.	ith the Ma or 28a-1s	Director	10e. Street and Number	0	, ,,	zeet	10f. Zip Code	/		10g. Citizen of What Co	·
4	<u>م</u>	within 72 hours after deeth with the Marylend ene. Then "naturel", or items 23e or 28e-f show he should be and en must be notified at		3408 E.	PRAT				224		U.5	
-	4	er de	Funeral	11. Marital Status	Armed Fo		13. V	as Decedent of F Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
>	36	s afte	by F	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc	If Yes, Giv	re ·	1	☐ Yes 2 No	Specify:		Specify:	hite
7	م- 003	hour ture	ed t		ent's Education		16a. Deced	ent's Usual Occup	pation		16b. Kind of Business	
V	الر 215	In 72	piet	(Specify only high	hest grade completed)	40551)	(Give I	ind of work done O NOT use retire	during most of work d)	ring	<i>C</i> ,	1 Dead
ナ	212	with iene.	Completed	Elementary/Secondary (0-12	College (1	-40(5+)	5	Alesw	CMAN		STEWAR	ets Dept.
W	, D	be filed tal Hygir d other event,	BeC	17. Father's Name (First, Midd	le, Last)					*	Maiden Surname)	) .
20	ian lan		ToB	Charles		WA	LKei		MAG	gie	P	ierce
2	9. aryl	E E E		19a. Informant's Name/Relation					and Number or Rui	ral Route Numbe	er, City or Town, State,	3 -
V	Σ	1 and 2 Heelth a em 27 le	1 0	CONNIE ZING	PARELLI- D				PRATT	Street	et Balt	O. HDZ1ZZ4
2	ore	of of or		20a. Method of Disposition  1 ■ Burial 2 □ Cremation	on 3 Removal from			ition (Name of atory or other pla	401	Date	20c. Location - City or	
0	Ĕ	Page nent o ant: if ury or		`4 □Donation 5 □ Other		OAF	LACUA	Cemet	ery Sept	20,2004	BAHIMORE	MARYLAND
ERND	Baltimor	permit. Pag Department Important: I any injury o		21. Signature of Funeral Servi	ce Licensee		22	Meme and Addre	ss of Facility	INO JR	- Funera	MARYLAND Home MD 21224
2	<u>m</u>	897		101/3	5	-	- 2	635.	CONKINO	5tre	et Bx Ito	MD 21224
J	- 1			23a. Part1. Enter the disease, shock, or heart failure.	or complications that calls only one cause on a	auseu life dealif.	Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Interval Between
二		Pnysician		Immediate Cause (Final disease or condition	. W	etasta	no	CUNC	CANC	CL		Onset and Death
•		/Medical		resulting in death)	a	(or as a conseque						
		Examiner		Sequentially list conditions.	b							
	1	p #	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to	(or as a conseque	ence of):					
		ecute and trans	Cam	that initiated events resulting in death) Last	c. Dua to	(or as a conseque	ance of):					
	90,	The law requires that the death certificate be executed site has been signed by the ettending physicien end page 2 should be detached for use as the burial-transit			Due to	(or as a conseque	ince on.					
	8760,	ate b	dicai		d							
	9	leath certific ettending p	/Me	IF FEMALE:	23c If yes ou	tcome of pregnan	cv				22d Date of de	livon
	Вох	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 prenths?	1 ☐ Live t	oirth 2 ☐ Fetal on nant at time of dea	death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of de Month	Day Year
		the e	ysic	in the past № pronths? 1 ☐ Yes 2 X No 9 ☐ Unknown	9□ Unkn		au	Other (specify) _				
	P.O.	that the de led by the e detached t		Part II, Other significant cond	ditions contributing to d	eath but not resul	ting in the ur	iderlying cause gr	ven in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
	ds,	w requires that s been signed is should be det	d by							1700	Yes 2□No 3□P	robably 4 Unknown
	0	requ	Completed							24a. Was	an 24h Were a	utopsy findings available
	3ec	has h	mpi							autop	prior to death?	completion of cause of
	E H	icete								1 Tes	2. No 1 □ Yes	2 □ No
	× X	icler certif recto	Be	25. Was case referred to med examiner?	Hospital:		'D/O	oczana Ot	26. Place of Dea		h	ecity MOSPICE
	of	Physical distribution	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date		R/Outpatien 28b. Time of	3 DUA	4 🗀 Nursing 🗅	ome 5 Residence Residence Page 1	now injust occurred	ocity MCCTA ICS
	n	ding After fune	tion	1 Natural 5 ☐ Per	/4/00	th, Day Year)	Injury	28c. Inju Wo M 1	irk? ]Yes 2⊟No		0.0	
	100	deatl deatl ctor: y the	lica	3 ☐ Suicide 6 ☐ Col	uld not be	of Injury - At hor	ne, farm, str	eet, factory, office		28f. Location (S	Street and Number or F	ural Route Number,
	Division of Vital Records,	or A efter Dire	Certification;	4  Homicide det	build	ing, etc. (Specify)				City or Tov	vn, State)	
		To the Hospitel or Attanding Physicien: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certi	fying Physicien: To the	e best of my know	rledge, death	occurred at the t	ime, date and place	, and due to the	cause(s) and manner a	s stated.
		Pe Ho	ledical	(Check only 2 Medi		nner stated.						
		Vithii Withii To th	Ž	29b. Signature and title of cer	tifier			29c. Licen	se number		29d. Date signed (Mon	th, Day, Year)
				Millo	ul my			DO	8303		September	-172004
		1		30. Name and address of per-	son who completed cau	se of death (Item	23а) (Туре,	Print)	1. 1+	R.14	in = ich	21702
	/. <u> </u>	H		HILLEN J.	Charles 1	My (	NOU!	Viele I	723 31	Balla	rolle. at	100
	1	St Regist	ate trar	31. Date filed (Month, Day, Yo	2 1 2004 32.	tenstrar's Signat	пер	7				th, Day, Year) - 17 2004 21204

Bal	
P.O. Box 68760,	
Vital Records,	
Division of	

		Plea	ise Type or Pri									_	э.	
		1 - For State Registrar	State of Ma	aryland /	-	rtment tificate				iental Hy				
62		Negistrar     Necedent's Name (First, Midd.	le, Last)			inouto	- 01 2	Joann		2. Date of D	Reg. No	200	3. Ti	me of Death
Physicia (Marchia		Scott Edward J	ohns, Jr.							Secten	her		354 9	40 PM
/Medic Examin		4a. Facility Name (If not institutio	n, give street and number)			4b. City, T	own, or	Location	of Death	201101		. County of [		
		North Arundel	Hospital			G1en		nie			A	nne A	rundel	
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last i	birthday) Yrs.	If Under 1 Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9.	Birthplace (S	tate or Foreign
Director		220-36-9304 Usual Residence of Decedent	X	66	113.					9/16/1	.937		ynchbu:	rg, VA
yland		10a. State 10b. County		10c. City, To	own or Loc	ation							10d. Ins	ide City Limits
e Mar He-f s	ctor	MD Anne	Arundel	Seve	rn								1	Yes 2 No
ith th	Director	10e. Street and Number				10f. Zip (					10g. Cit	izen of Wha	t Country?	
s 23a	sral	7852 W. B. & A	10.10		1144						SA			
ter de Item	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Mar	12. Was Decedent Armed Forces?		I3. V	Yes, specif	fy Cuba	spanic Ori n, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	0-		American Indi Vhite, etc.	an,
urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes Give 22		1	☐ Yes 2	No.	Specify:				Specify: V	√hite	
72 ho	eted		nt's Education	16	Sa. Deced	ent's Usual	Occupa	tion	t of work	na	16b. K	ind of Busine	ess/Industry	
be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Items 23a or 28e-f show event, the Madical Examitment instituted at	Completed	Elementary/Secondary (0-12)												
filed v Hygie ther t											Ller			
ld be ental ked o	To Be	Scott E. Johns	ŕ					Eva V						
shou and M s mar	-	19a. Informant's Name/Relations	ship (Type, Print)	1:	9b. Mailin	g Address (			_	l Route Numb	er, City o	or Town, Star	e, Zip Code)	
and 2 salth a n 27 i		Mrs. Virginia	Johns / Wife	7	852 1	V. B.	& A	. Roa	ad Se	evern,	MD 2	1144-		
ges 1 of He If Iter or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from State	1	tery, crem	atory or oth	ner place	· 1		ate	20c. Lo	ocation - City	or Town, Sta	ite
t. Pag tment rtant: njury		Chesapeake Cremation 9/15/2004 Stevensville, MD  21. Signature of Funeral Stevensee											ÍD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumetic event, Item Acted Examiner mat be retilled at once.		21. Signum ry of Funeral 3. Ilice	Licensee Mo 12											
		23a. Part1. Enter the disease, of	complications that caused	the death. D						en Bur		MD 21	Approx	ximate
Physician		Immediate Cause (Final	only one cause on each li	aceve	bra	I K.	ew	OVV	has	e				al Between and Death
/Medical		disease or condition resulting in death)	и	a consequenc					1					
Examiner		Sequentially list conditions.	b. Dial	setes		uit	NS							
ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	ā consequenc	. <del>a</del> 01).								01	
executed an and rial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):												
icate be ex physician s the buria	_	d												
ntificat ng phy as th	Medi	IE EENAN E												
ath cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy									Vans	
The law requires that the death certificate be to have been signed by the attending physicial bage 2 should be detached for use as the bur	Physician/Medical	1 Yes 2 No	4 Pregnant at time of death 5 Other (specify) Month								Day	Year		
that the ed by detac	/ Ph	Part II. Other significant conditi	ons contributing to death b	ut not resulting	in the un	derlying car	use give	n in Part I.		23e. Did 1	obacco u	ise contribut	e to the cause	of death?
puires n sign ald be	d by					, ,				10	Yes 2	□No 3□	Probably	4 Unknown
aw red as beer 2 shou	Completed									24a. Was				ipos available
sicien: The lav certificate has rector, page 2	L O							-		auto perfo 1 ☐ Yes	psy ormed 2 No	prior death		
sien: artifica ctor, I	Be C	25. Was case referred to medica examiner?						26. Place	of Death	(Check only				
hysio this co	ပ္	1 ☐ Yes 2 12 No	Hospital:			3□ DOA		4 🗀 IVU		ne 5□Resi			pecify)	
ding F h. After funer	tion	27. Manner of Death  1 Natural 5 Pendin	28a. Date of Inju ng (Month, Daj gation	Year) 28b	. Time of Injury	м 28	c. Injury Work	at ? es 2 🗀 l		28d. Describe	how injur	y occurred		
Attender deat	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Injuried	ury - At home,	farm, stre					28f. Location (	Street an	d Number or	Rural Route	Number,
al or safter	Certification:	4 ☐ Homicide determ	building, etc	c. (Specify)						City or To	wn, State	)		
To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifyii	ng Physician: To the best Exeminer: On the basis of	of my knowled	ge, death	occurred at	t the time	e, date an	d place, a	and due to the	cause(s)	and manner	as stated.	100(0)
the P hin 24 the P mplete	Medi	20h Cianatura and title of contific	and manner sta	ited.		200	Lionneo	number			20d Dat	a signad (M)	anth Carri Va	
P W P S	>	29b. Signature and title of certifie	7 (1) il	W	n.D	290.	04	136	25		Coot	o signed (M	onth, Day, Ye	2004
11		30 Name and address of person	who completed cause of d	eath (Item 23a	(Type P	krint) -	- L	, -			Jet 1	E.A.	1	1 - 1
11					01 H	USpit	al	Driv	e, C	den B	UVV	الم را	٧, 21	061
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State Registrar DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene For State Registras Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mae Kethlev 9:10 p M 15, Sept. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X Days Hours Yrs Director 73 3, MS 428-40-8820 Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Madical Examinar must be notified at 1 X Yes 2 ☐ No Director MD Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20878 12324 Sour Cherry Way United States Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2☐ No If Yes, GiveX Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) housewife housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown unknown ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n any injury or other traun <u>once.</u> Robert B. Kethley, husband 12324 Sour Cherry Way, North Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation ☐ Other (Specify) San Jacinto Memorial Park 9/20/04 Houston, TX 21. Signature of Fune al Service Licens 22. Name and Address of Facility Rapp Funeral and Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helpit failure. List only one cause on each line. 20010 proximate Interval Between Onset and Death Immediate Cause (Final Physician struction bowe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit certificate be executed that initiated events resulting in death) Last P.O. Box 68760 attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Machine Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 2) No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospice Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of De 1th 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 🗌 Yes after death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) within ? 29c. License number 29b. Signature and title of certifier D31391 empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person zraa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item # 10e per FH C835 9/21/04 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** A. KELLY 1ARY 09 18 2004 1602 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pencrial BALLIMORE HOSFITAL Voice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth \_\_(Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Director ai7 24 5120 VIRGINIA Usual Residence of Decedent works 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Yes 2 □ No Directo DARATHED BALLIMORE 10e. Street and Number 1543 Kennewick Rd, 10f. Zip Code 10g. Citizen of What Country? 21218 2-S-A Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) PRINT 84RS-BICKOIN-DIKERSONIA HNICIAN 120 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BROWN ပ LAWRIMS ROFFIT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Heelth a Important: If item 27 is any injury or other trau MARTIAN CHRISTINE ELLEN 3040 E0 EE W000 Baltimore, 20b. Place of Disposition (Name of cemetary crematary or other place)

22. Name and Address of Facility = 12. Name and Ad 20a. Method of Disposition 20c. Lostion - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State LINKNOWN 4 Donation 5 Qther (Specify) FORESTHUL MARYLAND 21. Signavire of Funeral Dervice Licens CRILS 46616 1921/AND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 7 days LUNG CANCER /Medical Due to (or as a consequence of): Examiner PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed ATRIAL FILLATION Due to (or as a consequence of): attending physician Box 68760 Physician/Medical 94) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the i detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed??
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No 2 1 ☐ Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical The Certifying Physician. To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 09,18,2004 ATZ438946 - E8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University Parkway, Baltimore, MD 21218 GAUTAM GULATI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 2 1 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Towa Potember 16. 200 muno /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimo re Rosedale

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Franklin Woods Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 GM 2□F MAryland 216-30-7961 68 Yrs. Director Nov. 27, 1935 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Medical Examiner must be notified at MD Baltimore 1 Yes 2 No Middle River Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12939 Cunninghill Cove Road 21220 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ģ Specify:White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AM Track Conductor 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumstic event SDE. Be Sigmund J. Kowalski Virginia Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Kowalski wife 12939 Cunninghill Cove Road Balto.MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) BayviewCrematory 9/20/04 Baltimore MD 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 Onne 23a. Part1. Enter the disease of complications that caused the dealif. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ٥ Day 5 Other (specify) ☐ Yes 2 ☐ No should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed? certificate 1 Tes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ဥ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and add Ism Edmondson Franklin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2 1 2004

			For State Registrar	tate of Maryla		artment of H		nd Men		ene No 200	1. 29720
	Physici /Medic		1. Decedent's Name (First, Middle, Last)			Kirb	24	Se	pate of Death Month	17 78	
	Examir Funeral	ner	4a. Facility Name (If not institution, give stre  The John Hopk  5. Social Security Number  214-30-2623  6. Sex	ins Hosp	rs. last birthday)  Yrs.	4b. City, Town, of Bellin If Under 1 Year Months Days	If Under 2	u C	rate of Sirth Month, Day, Y	4c. County of E	Birthplace (State or Foreign County)  aryland
	Director wods	or	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation		pec	24,	1930   14	10d. Inside City Limits 1 □ Yes 2 💆 No
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23s or 28s-1 show other treumatic event, Ite Medical Exertified at	Funeral Director	10e. Street and Number 17001 Troyer Road	Was Decedent Ever in Armed Forces?	u.s. 13. y	10f. Zip Code 21111  Vas Decedent of Ff Yes, specify Cub	lispanic Origi	n? (Specify '	U		t Country?  American Indian, White, etc.
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	d be filed withi sntal Hygiene. ted other then c event, It e M	Be	17. Father's Name (First, Middle, Last) George Washington P	ierce	Homema			s Name (Firs		wn Home	
re, Maryland	1 and 2 should be Health and Mental em 27 is marked o	To	19a. Informant's Name/Relationship (Type, John W. Kirby / 20a. Method of Disposition	Print) husband	17001	g Address (Street Troyer sition (Name of	and Number	or Rural Rou	n, MD		
Baltimore,	permit. Pages Department of I Importent: If Ite any Injury or of		1 Burial 2 Cremation 3 Rem '4 Donation 5 Other (Specify)  21. Signature of Purperal Service/Licensee	oval from State	illtop Ser	rvice Corp.  Name and Addre	9 ess of Facility	/20/04		wson, M 1050 Yo	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one disease or condition resulting in death)	ions that caused the de- ause on each line.							Approximate Interval Between Onset and Death
8760,		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a cons	pivat	ory for	ailu	r C			I month
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23c.  23c.  in the past 12 months?  1  Yes  You	If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	ý			23d. Date of Month	delivery Day Year
ecords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contrib	outing to death but not r	esulting in the ur	nderlying cause gr	en in Part I.		23e. Did tobac		e to the cause of death?  ] Probably 4 SUnknown
Vital Rec	(G LL	Be Completed	25. Was case referred to medical				26 Place o	1	24a. Was an autopsy performed Yes 2	prior	
of	ding Phys	7	examiner?  1  Yes 25 No Hos  27. Manner of Death  15  Natural 5  Pending 2  Accident investigation	pital: Impatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	ier: 4 🗌 Nurs	ing Home 28d. [	5 Residenc	e 6 □Other (5	Specify)
Division	5 th 15 c	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	ocify) 	•	mo data and		City or Town, S	itate)	r Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in I	Medical	(Check only one)  2 Medical Examiner  29b. Signature and title of certifier	On the basis of examinand manner stated.	ination and/or inv	vestigation, in my o	pinion, death	occurred at	the time, date	e(s) and manne and place, and Date signed (M	due to the cause(s)
	1.		30. Name and address of person who comp	leted cause of death (If	tem 23a) (Type.	Print)	85-1	500	Se	ptember	- 18,2024 D Z1ZID
	Sta Regist		Brenda A. Shoo 31. Date filed (Month, Day, Year) SEP 2 1 2004	32 degistrar's Sig	nature	ty Pkwy	#512	2 SA	ltin	orly hi	01212

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			Registrar  1. Decedent's Name (First, Middle, Last	Jortinicat	e or be	aur	Reg. 2. Date of Death	NO. 0 0 4	3. Time of Death			
	Physici	an								2004 Year	12:13p <sup>M</sup>	
	/Medic		Serena Smyser 4a. Facility Name (If not institution, give			4b. City.	Town, or Lo	cation of Death	DOP CO.	4c. County of Death		
	Examin	er					ockvi1			Montgomery		
	uneral		Casey House  5. Social Security Number 6. Se	7. Age	(In yrs. last birth		1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		place (State or Foreign intry)	
	irector		348-46-7487	]м 2 <sup>4</sup> 5 F	94 Yr	rs. Months	Days F	lours Min.		1910 Pen		
D			Usual Residence of Decedent						vept. 1.J	1310 1611		
rylan	how	_	10a. State 10b. County		10c. City, Town						10d. Inside City Limits	
e Ma	3a-f s	cto	MD Montg	omery	Kei	nsingto	n 				1 ∑Yes 2 □ No	
ith th	or 2	Director	10e. Street and Number			10f. Zip			10g.	0g. Citizen of What Country?		
ath w	238	rai	3620 Little Dale					895		United S		
ar de	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dece If Yes, spe	dent of Hispa cify Cuban, ໂ	anic Origin? (Sp Jexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White		
rs aft	0 1	by F	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	1 □ Yes 2 XN If Yes, Give Year or Dates:	0	1 🗆 Yes	2 <b>∑</b> No S	Specify:		Specify: wh	ite	
filed within 72 hours after death with the Maryland	tura E E		15. Decedent's Edu		16a. D	ecedent's Usu	al Occupation	n	161	. Kind of Business/Ir	ndustry	
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ad blu	rked rked iic e	To B	Adam Milton Smyse	er			İ	Miriam	Stein Sm	yser		
shor	s ma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
and 2	27 l er tre		Nellie L. Longswor	th, Daugh	ter 5	5202 Ca	r1ton_		Bethesda	, MD 208	16	
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mit.	Department or nearth and whenta rygene. Important: If item 27 is marked other than any injury or other traumatic event, the Me ODGS.		21. Signature of Funeral Service Licens	1/00/00	_/	22. Name ar			remation	Corre		
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idso	uner uner			sician: To the best oner: On the basis of								
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O	To	2	29b. Signature and title of certifier			29	License nu		29d.	Date signed (Month,		
•	42		" It-Cal		MAN 1			35635		Sept. 14,	2004	
	1)		30. Name and address of person who ca					L				
			Joseph Kaplan	6001 Munc	aster Mi	11 Road	l, Roc	kville,	MD 2085	2		
	Sta	ite	31. Date filed (SPIPDay Year) 1014	2. Hegistra	r's Signature	nach !						

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Examin Funeral Director	er	5. Social Security Number 6. S	OF BALT	TMOR e (In yrs. las 83	E birthday)_	b. City, Town, of BACT funder 1 Year fonths Days	Mol	ler 24 Hrs.	8. Date of Bi (Month, D. 2-23	rth	County o	D	
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be filed within 72 hours after death with the Maryland ital Hygiene. Ad other then "natural", or Items 23e or 28e-f show event, it e Modical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 XYes 2 N If Yes, Give Year or Dates:		4/42		lispanic (		pecify Yes or No Rican, etc.)	p- 1		- Americ , White,	
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inatine de ned by the a detached	y Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ng in the unde	rlying cause giv	en in Par	t I.	23e. Did t	obacco us	e contrib	ute to th	e cause of death
quires in sign	ed by								1 🗆	Yes 2□	No 3	Prob	ably 4 Onkno
The law requirate has been page 2 should	Completed								24a. Was autoj perio 1 🗆 Yes		pric dea	ere autop or to cor ath? Yes	osy lindings availander of cause
rnysician: In this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00		h (Check only o				
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를 를 들	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify)								Street and vn, State)	Number	or Rura	Route Number,
To the Hospitel within 24 hours a within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 15 Certifying Ph (Check only one) 15 Certifying Ph 2 Medicel Exer	ysicien: To the best on niner: On the basis of and manner sta	examination	edge, death or and/or inves	curred at the tin igation, in my o	ne, date a pinion, de	and place, eath occurr	and due to the ed at the time,	cause(s) a date and p	nd mann place, and	er as sta d due to	ated. the cause(s)
To tha b within 24 To tha f complete	W	29b. Signature and title of certifier  Donnal E  30. Name and address of person who	2-6	ND		29c. Licenson				29d. Date	signed (i	Month, I BER	Day, Year) 12, 200
Sta		30. Name and address of person who DOUCHAS E - RAMS 31. Date liled (Month, Day, Year)	ecompleted cause of de EY, MD, SIN 32. Registra	Af H	Sa) (Type, Prince)	LOFI	BACT	7MOR	E, BA	LTIL	NORE	= 1·	1D 2121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** EUGENE MATHES SEPT 17 12:30 P 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10 TERRON COURT PARKVILLE
If Under 1 Year | If Under 24 Hrs. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F 84 Yrs. Director 245-46-8805 09/14/1920 N. CAROLINA filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itame 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10 TERRON COURT Completed by Funeral 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces: 1 □ Yes 2 □ No IVA s, Give Year or Dates: US 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK 3√2 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hyglene. Elementary/Secondary (0-12) US GOVT Callege (1-4or 5+) 9TH SHIPPING/RECEIVING ABERUE
18. Mother's Name (First, Middle, Maiden Surname) ABERDEEN PROV GRD permit. Pages 1 end 2 should be file Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth any liquy or other treumatic event ans. 17. Father's Name (First, Middle, Last) Be COOSTER MATHES HANNAH AVERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA MATHES/DAUGHTER 10 TERRON COURT, BALTIMORE, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD VETERANS CEM
GARRISON FOREST 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 9/23/04 OWINGS MILLS, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 HGHTS AV, BALTIMORE, MD 4600 LIBERTY re-se, or complications that caused the lure. List only one cause on each line. h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ock, or heart Imme liat - ause (\*nal disea - r condition resulting in death) **Physician** MYDIARDAL INFARCTION, PROBABLE /Medical Due to (or as a consequence of): Examiner HYPERLIENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physiclen and s the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Stesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 1 🗌 Yes 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel I Decrtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

AWSEL

31. Date filed (MSE Pay 2 ear) 2004

MP

leted cause of death (Item 23a) (Type, Print)

1000

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mion Year 0 /Medical 200 20 20 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeakel 5. Social Security Number 6. Sex 6 Age (In yrs. last birthday)

Yrs. Be **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 334-32-69(a Days 1 □ M 20 F Hours Min. Director LILINOIS Usual Residence of Decedent with the Maryland 10a State ortent: If item 27 is marked other than "naturel", or Items 23e or 28a-f show injury or other treumatic event, the Madical Examilizer must be natified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Har 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 212 No þ Specify: 3 Widowed 4 □ Divorced Specify: White. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, Importent; if item 27 is marked other than " any injury or other treumatic event, the Mac. Once. Elementary/Secondary (0-12) College (1-4or 5+) omemaker 20 ma 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Glorge Ma 19a. Informant's (Na Relationship (Type, rint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21013 Date 20b. Place of Disposition (Name of cametary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 9-20-04 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility FOREST HILL, MD 23a. Part1. Enter the disease, or shock, or heaft failure. List NO C EVANS FUNERAL CHAPEL-BEL 3 NEW PORT DR AIR. complications that caused the Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of): burial-transit requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1☐ Yes 2 NO 1 Yes Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 70 1 Dispatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No in by the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who comp (Item 23a) (Type, Print) Stree 31. Date filed (Month. Da State Registrar 2004

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	160 A		Registrar  1. Decedent's Name (First, Middle, Last	)		, , ,	Julii 1	2. Date of Deat		3. Time of Death
- 15°	Physici /Medic		George ALG	irt	McDo			Month	ber 20 200	× 130 AM
	Examir	er	4a. Facility Name (If not institution, give	1	( la - 4b.	City, Town, or Lo	ocation of Death	1.11	4c. County of Deal	h
,9k	Funeral Director		5. Social Security Number 6. Se	AVVIEW COLE 7. Ago (In yrs.			f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bin	hplace (State or Foreign suntry)
	and		Usuat Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Location	1				10d. Inside City Limits
	e-f sho	ctor	MARYLAND	BF.	Limore					Yes 2□No
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Baltimore,	of of		20a. Method of Disposition  ↑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	Place of Disposition cometery, crematory	(Name of or other place)	1922	Date :	20c. Location - City or	Town, State
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of V	G is	To B	TOS ZENO						nce 6 Other (Spec	sity)
	Jing Alter fune	tion:	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe ho	w injury occurred	
Division	E : 0	Certification:		28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fa		. 2	28f. Location (Str City or Town	eet and Number or Ru , State)	ral Route Number,
_	To the Hospitel or Atte within 24 hours after de To the Funerel Directo ormpletely filled in by th	edical Co	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occu ation and/or investig	rred at the time, ation, in my opinio	date and place, on, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
Se .:	No the Vithin To the	Me	29b. Signature and title of certifier			29c. License nu	umber	29	d. Date signed (Month	n, Day, Year)
	6		1 74500	me		D47	479		09,28	,2004
	4		30. Name and address of person who co	impleted cause of death (Item	n 23a) (Type, Print)	Bal	£2	RYL	AND	,
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	1		1		

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Vaar Month Physician 8:05P M Mary Catherine Magruder September 16,2004 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) March 6,1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** Min. Days 1 □ M 2 1 F Months Hours 213-14-3600 Yrs 84 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ž No Specify: White Specify 3 Nidowed 4 Divorced 'natural', 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene. If item 27 is marked other then or other traumatic event, the Me. Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry H. Hening Rose E. Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Beech Leaf Court Towson, Maryland 21286 Margaret Cronyn (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or \* 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 9-21-2004 Brooklyn Park, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, 1630 Edmondson Ave. Catonsville, MD 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Parkinson Diseuse /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year for Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown 9 Unknown à signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 110 to the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After Injury 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No death. investigation 2 Accident Director: / 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours after To the Funeral Dire 29a. Certifier 114 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Lane, Catonsville, mo Divisella Bowlin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month AM 2004 BARBARA ANN MAIDA 9 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A STELLA MARIS-MERCY HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea 1/21/1933 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign untry) W YORK Months 1 M 2 D₹ 050-26-4947 NEW Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits N/A DUNNELLON 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34432 19245 SOUTHWEST 98 Loop USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12TH GRADE 17. Father's Name (First. Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER TRACY BARBARA MULLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19245 SOUTHWEST 98 LOOP DUNNELLON, FL WILLIAM J. MAIDA HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State CALVERTON NATIONAL CEM. 9/23/04 CALVERTON, NY ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final morphoid awto disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 🗌 Yes 2E No 25. Was case referred to medical

**Physician** /Medical **Examiner** 

Department of Importent: If it eny injury or o

**Physician** 

/Medical

Examiner

Director

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Completed

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 286-f show other treumetic event, it a Modical Examiner must be notified at

d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "n

death with the Maryland

IAIDA, BARBAK

the burial-transit certificate be executed physician use as ģ ۵

Vital Records, P.O.

Hospital or Attending

24 hours a

within 24 ho To the Fune completely fi

Physician/Medical þ page 2 should Completed Be After this Certification: after death Director:

23b. Was decedent pregnant

26. Place of Death (Check only one)

examiner' Other: 4 Nursing Home 5 Residence 6 Pether (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 🗌 Yes 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? М 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

to the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and the of certifier

1-Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

29c. License number

JU8541

29d. Date signed (Month, Day, Year) 9/20/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TC Baltimore

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 2 1 2004

6 Could not be



and manner stated

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat September 18, 2004 **Physician** Frances Rose Mack 6:45PM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2 Thurmont Court Apt. T-C Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV.5, 1931 **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🙀 F 216-28-2269 Director 72 Maryland Usual Residence of Decedent 1 and 2 should be filled within 72 hours after death with the Maryland Health and Menial Hygiene.
37 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov dical Examiner must be notified at Director 1 ☐ Yes 2 ▼ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Thurmont Court Apt. T-C 21236 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Barber Barber Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kortesis Louis Mary Lemoides ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Mr. Bonaventure Mack- Husband 2 Thurmont Court Apt. T-C Baltimore, Maryland 21236 item ( 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State to = 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Greek Orthodox Cem. 9/21/04 Woodlawn, Maryland Heather 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cain Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 Llatus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INTERSTITIAL disease or condition resulting in death) -42045 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Dive to (or as a consequence of) for use as the burial-fransif Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the affending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Yea 4 Pregnant at time of death 5 Other (specify) afe has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P 🔻 I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificafe has autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) No Certification: To 1 Tyes this 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No affer death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 18326 9/20/04 Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE NAEEM GAUHAR, ESSEX MEDICAL CENTER, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar SEP 2 1 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day MASKELL Month Year **Physician** 7 00 A M JAMES A. 09 2004 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD GOOD SAMARITAN HOSPITAL BALTIMORE, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 3 M 2 □ F Months Hours 218-28-9573 70 Director 4/11/1934 <u>Maryland</u> Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location ir than "natural", or Itame 23s or 28e-f show the Medical Examinant the notified at 10b. County 1 ☑ Yes 2 ☐ No Directo N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6008 Burgess Avenue U.S.A. 21214 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. e filed within 72 hours after call Hygiene.

Other then "natural", or Itan 1 Never Married 2 Married 1 ☐ Yes 2√XNo If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of MD. Elementary/Secondary (0-12) College (1-4or 5+) 5 Truck Driver Bureau of Highways nd 2 should be filed alth and Mental Hygis 27 le marked other ir traumatic event, III Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be es 1 end 2 should b of Health and Menta if Item 27 le marked ir other traumatic e Daniel V. Maskell Marie Gray 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Maskell 6008 Burgess Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Importent: If It eny injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Balto./Wash. Crem. 9/21/04 Laurel, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part. Enter the disease, or complications that eauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PULMONARY DISEASE Immediate Cause (Final disease or condition resulting in death) SEVERE CHRONIC OBSTRUCTIVE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by sign be CONGESTIVE HEALT FAILURE 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 1 Yes 2 No certilicate 1 Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD Makounen, D0058009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLVD. BALTIMORE, MD ZELALEM MAKONNEN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 1 2004

3. Registrar's Signature

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, per Phy. 6835.9/21/04 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MECRI+T 12: 46 PM SEPT EMBER DESSERAY 17 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOS PITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 Months Days Hours 34 Director 10 1970 LOUISIANA 433-57-6061 AUG. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or itams 23s or 28s-f show the Medical Exeminar must be notified at 1 ☐ Yes 2\No Directo MARYLAND HARFORD CO ABERDEEN 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3909 B FREEDOM COURT 21005 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. l⊠Yes 2 □ No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) U.S. AIRFORCE MILITARY 1 year 12th grade or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi and Mental F is marked of CLIFTON GUILLORY ELLNER GUILLORY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an ent: if item 27 is a Derik Merritt/Husband 3909 B. Freedom Ct., Aberdeen, Md., 21005 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 09-25-04 GARDEN OF MEMORY ALEXANDER, LOUISIANA 21. Signature of Fundal Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Cardiomyopathy Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 DAMS **Physician** /Medical Due to (or as a consequence of): Examiner HEART MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No his funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospitei 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MITHANI SCRTEMBER DOCTOR LCS-000 SUMME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATIMORE, MARLY LIMED STREET 600 NORTH WOLFE MITHANS SVHAIR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar SEP 2 1 2004

68760,	
P.O. Box	
Records,	
of Vital	
Division	

		State of Maryland / Department of He		-	_	ible.	
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		1. Decedent's Name (First, Middle, Last)		2. Date of Dea	Reg. No.,	1329	3. Time of Death
Physicia		Francis E. McLaughlin		Month 9	Day 15 6	2004	9:22 1M
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or L	Location of Death		- 1	y of Death	
LXumm		FRANKLIN SQUARE HOSPITAL ROSED	dale		B41	Timo	RE
Funeral		5. Social Security Number 0 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h y, Ye <i>ar</i> )	Count	
Director		218-18-5815 78 Yrs.		10/17/	1925	Mary	Land
land		10a. State 10b. County 10c. City, Town or Location				10	d. Inside City Limits
Mary -f sh	tor	Md Baltimore Essex					1 ☐ Yes 2 ☐ No
n the	Director	10e. Street and Number 10f. Zip Code			10g. Citizen of	What Count	ry?
filed within 72 hours after death with the Maryland Hygiene. uther than "netural", or Items 23a or 28a-f show ent, the Medical Eracular printed by colligiscal		1006 Kayden Lane 21221			U.S.A	L •	
ltems	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of His If Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto F	cify Yes or No- Rican, etc.)	- 14. Ra Bla	ce - America ck, White, e	
s afte	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Year or Dates:	Specify:		Speci	<sub>fy:</sub> White	e
permit. Pages 1 and 2 should be filed within 72 hours popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", any injury or other traumatic event, the Medical Eragonee.		15 Decedent's Education 16a Decedent's Usual Occupati	tion		16b. Kind of E	Business/Indi	ustry
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2 sh and Is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and					Zode)
1 and Health		Lawrence Anderson 1006 Kayden La:  20a. Method of Disposition (Name of camelery, cramatory or other place)		, Mary	1and 21 20c. Location		wn, State
nt of I		1 Li Buriai 2 Cremation 3 Li Hemovai from State	1	2004			
artme ortani injury		'4 □ Donation     5 □ Other (Specify)     Bayview Crematory       21. Signature of Funeral Service Licensee     22. Name and Address	09/17/		Baltimo		
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		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.					Approximate Interval Between
Physician	00						Onset and Death
/Medical		resulting in death)  Due to (or as a consequence of):					
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Respiratory Failure  Due to (or as a consequence of):  b. Me TASTATic ProsTATe  To be to (or as a consequence of):	CAR	cino	m4		
be slt	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
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that the death cer ed by the attendir detached for use	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			М	onth [	Day Year
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The law requires that the death certifical tie has been signed by the attending phy age 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Pan I.	1 🗆 Y	<b>1.</b>	3 ☐ Proba	
requ	Completed			24a. Was	/	Vá/oro suton	ov findings available
ne law has l	mpi			autop perfor	rmed?	prior to com death?	sy findings available pletion of cause of
	e Co	25. Was case referred to medical	26. Place of Death		2 💢 No	1 Yes 2	2 □ No
/sicie s cert directo	0 B	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA				her (Specify)	
Attending Physicien: r death. ector: After this certific by the funeral director,	T :u	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury 2	at 2	8d. Describe h	ow injury occu	rred	
andin ath. or: Af	atio	2 Accident investigation M 1 Ye	es 2 🗆 No				
r Att ter de irecton n by ti	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (S City or Tow		ber or Rural	Route Number,
urs al		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time	data and place a	nd due to the			tod.
To the Hospitel or Attending Phys within 24 hours after death.  To the Funerel Director: After this: completely filled in by the funeral director.	edicai	(Checkfoly 2   Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.					
o the	Me	29b. Signafure and tile of certifier 29c. License	number	0	29d. Date signe	ed (Monh, D	ay, Year)
->-0		DOO	5441	5	711	5/6	4
5/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1		t	1
IJ		DRS/VIA MORRIS 9000 FRANKIN SQUARE  31. Date filed (Month, Day, Year)  32. Registrar's Signature	DR. BA	ITi moi	REMO	121	237
Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature					
negisti	- CII	SEP 2 0 2004 Server 15 poortes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If pot institution, give street and number) 3409 BALTI MORE
If Under 1 Year If Under 24 Hrs. 8 Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Social Security Number Days Hours Yrs 2/3-70-32/C 10-10-55 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 □ No MD ALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2123 HITE . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. ☐Yes 2☐No fYes, Give rear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify WMYE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maideh Sumame) 17. Father's Name (First, Middle, Last) arrigan lorman 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTINGTE, MD 2122.
Date 20c. Location - City or Town, State MO 21234 barbara Orlando Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removal from State 9-2004 Timonium MD 4 □ Donation 5 □ Other (Specify) Valley Nem Gardens 22. Name and Address of Facility BALTI MORE, MD 21234. 21. Signature of Funeral Service Licenses EVANS FUNCEAR CHAPER, 8800 HARFORD RD HOLL Approximate
Interval Between
Onset and Death

Minute daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day

**Physician** /Medical **Examiner** 

Department Important: bany injury o

**Physician** /Medical

**Examiner** 

**Funeral** 

Director

a 23a or 28a-f show

or Itema

men of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or Item jury or other traumatic event, Ite Madical Exardirat

death 1

filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Examiner physician a s the burialby Physician/Medical attending p ed by the a detached f Completed Be Certification: To Director: After th

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 1 Nafural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

4☐Pregnant at time of death 9 Unknown

1 Inpatient

28a. Date of Injury (Month, Day Year)

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 □Other (Specily) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Yes 2 No

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and ittle of certifie se of death (Item 23a) (Type, Print)

SEP 2 1 2004

5 Pending

investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

filled in by

Medical

within 24 hours after To the Funeral Dire To the Hospital

> od Day. Date liled (Month

32 Registrar's Signature

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Injury

			For State Registrer	State of M	aryland / Dep <i>Ce</i>	ertificate of		•	giene Reg. No. 1	1. 297	51
	Physici	an	Decedent's Name (First, Middle, La	15		-		2. Date of De Month	Day	Year	
	/Medio	al	James  4a. Facility Name (If not institution, give	re street and number		1son	or Location of Dea		ber 14,		) A M
	Examir	er	Clinton Nursing			Clinto				e George's	3
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last birthda 84 Yrs.		r If Under 24 Hrs		th	9. Birthplace (State of Country) South Car	or Foreign
	ס		Usual Residence of Decedent								
	aryler	_	10a. State 10b. County		10c. City, Town or					10d. Inside C	
	28e-1	Director	Maryland   Prince	George's	Upper Ma	10f. Zip Code			10g. Citizen of V		
	3a or	0	7823 Locris Dri	ve			772		U.S.A	•	
	deeth	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13		Hispanic Origin? (	Specify Yes or No rto Rican, etc.)	- 14. Race Blace	e - American Indian, k, White, etc.	
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50	22 = 3	Completed	15. Decedent's E (Specify only highest gra		(Gin	edent's Usual Occ re kind of work don	e during most of wo	orking	16b. Kind of Business/Industry		
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Marylan	Mentel Mentel rked o	To B	Joseph Nelson				Mattie	Young			
	2 should bend Ment in marked		19a. Informant's Name/Relationship (	-		•	et and Number or R		-		
	Haelth Ham 27 other tr		Mattie Christine	Blake - Da	aughter 7		ls Drive	Upper Mai		MD 20772 City or Town, State	
Baltimore,	0 = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 C		cemetery, cr	ematory or other p	lace) Park   9-13			t Hills. P	۸ (
Ħ	permit. Pag Depertment Importent: eny injury once.		<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service □</li> </ul>	•					TTCasan	it milis, i	А
Ba	Depentit. I Depertim Importer eny inju		Jacup. u	doold		449 Mit	ress of Facility Funeral He chell Ave:	nue Cla			
-	Physician		23a. Part : Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each l	g the deeth. Do not e ine.	ghely s	L Mo	Stalv	rrest,	Approximat Interval Bet Chset/and	ween
	/Medical Examiner		ſ	b/	a consequence of):	tion	0			In	
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О. Вох	it the death certificete be executed by the ettending physician end teched for use as the burial-transi	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown		23d. Date Mor	e of delivery onth Day *	Year			
Ω,	ras that i igned by be deter	≨	Part II. Other significant conditions	contributing to death I	out not resulting in the	underlying cause of	given in Part I.			ibute to the cause of d	
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o		.T	1 ☐ Yes 2 ☑ No 27. Manyler of Death	28a. Date of Injur	ury 28b. Time	of 28c, ini	ury at	Home 5 Resid	dence 6 □Othe now injury occurre		
on	th. :: After e funar	to	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year) Injury	W	'ork? ∐Yes 2∐No				
Division	or Attending efter death. Diractor: After	Certification;	3 Suicide 6 Could not be determined	286. Place of in	jury - At home, farm, stc. (Specify)	Street and Number vn, State)	er or Rural Route Num	ber,			
	Hospita 4 hours Funarati	Medical C								nner as stated. and due to the cause(s	;)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29d. Date signed	(Month, Dey, Year)						
	- > = 0		MD Attender 5-24535 09 14 04								
	V		30. Name and address of person who							/////	
	-		Laxmi Berwa, M.D		700 Old Br	anch Ave.	, Clinton	n, MD #C	101		
The Section of	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 1 2004	Seneral Services	rar's Signature	bouls					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** PERTER 2:58 AM ROBERT E. SEPTEMBER 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMURE GOOD SAMARITAN HOSPITAL 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** 10 M 20 F 318-14-9470 Director MARYLAR Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylant Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinator must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 100 Director BALTIMORE PARKUILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 8126 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 // Yes 2 | No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: LUDITE 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elsie Mai ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonter Kd, MD Jarion 20b. Place of Disposition (Name of cemetery, crematory or other place)

FUH NS FUN EVAL CHAPT- 9-22-0. DETILL

22. Name and Address of Facility MORE, MD 2123 - APP CHAPTER, SSCHARFORD

App 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause of seach line. EVANS FUNDERALCHAPER, SSOCHARTURIO ICA Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE RESPIRATORY FAILURE /Medical Due to (or as a consequence of) Examiner ACUTE CEREBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Winknown HY PERTENSION 24b. Were autopsy findings available prior to completion of cause of death? funeral director, page 2 autopsy performed 1 Yes 2 No 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 \_\_npatient examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD RES 000 SEPTEMBER 19 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLIVIER MD 5601 LOCH RAVEN BLUD BALTIMORE MD 21239 GOOD SAMARITAN HUSPITTAL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 1 2004 Registrar

DHMH 17 Rev 1/2001

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KOBERT L

Physicia	an	1 - State Registration TTEM  1. Decedent's Name (First, Middle  Dolores	Caroline	Pio	ckert		2. Date of Dea Septemi	ber 10,	2004 3	3. Time of Death 2230
/Medic Examin		4a. Facility Name (If not institution 9011 01d Ki	ln Road		Emmi	or Location of Death itsburg			ederick	
Funeral Director		5. Social Security Number 178-44-3304 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birth	Months   Days		8. Date of Birtl (Month, Day Feb, 27	h , <i>Year)</i> , 1952	9. Birthplace Country) Phil	e (State or Fore 1a. Pa.
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is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exert are must be notified at	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marria 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	13. Was Decedent of lif Yes, specify Cub		pecity Yes of No- o Rican, etc.)	Specify	ce - American I ck, White, etc. y: Whit	
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Pasqual Day Marie September 18, 2004 11:40AM Angela 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Hospital Baltimore HOPKINS The Johns 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months Days Hours 1□M 257F 232-32-6707 Jan. 9, 1929 | West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Bel Air Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 507 Country Walk Court 21015 USA Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Barber Virginia Veltri Patsy Glenn 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 507 Country Walk Court, Bel Air, Maryland 21015 of Disposition (Name of Date 20c. Location - City or Town, State <u> John Pasqual, Jr. - Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4 Donation a Other (Specify) 21. Signature of Financial Septice Licensee Highview Mem. Gardens 9/22/04 Fallston, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9 days Due to (or as a consequence of): months neutropenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): months acute myeloid Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 1° Naturel 2 ☐ Accident 5 Pending

/Medical Examiner ettending physician and for usa as the burial-transit Hospital or Attending Physician: The law requires that the death certificeta be executed page 2 s this Director: After thi To the Hospitai within 24 hours of To the Funeral C completely filled

**Physician** 

/Medical

Examiner

Funeral Director

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Be Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 ie marked other than "natural; or Items 23a or 28e-f show eny injury or other treumatic event, the Medical Examinar must be notified at

**Physician** 

Examiner

Physician/Medical

Completed by

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Certification: 4 Homicide edicai 29a. Certifier (Check only one)

3 Suicide

investigation 6 Could not be determined

28a. Date of Injury (Month, Dey Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier ▶ Angeline Chong, Medical Doctor

29c. License number

29d. Date signed (Month, Day, Year) 18,2004 September

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angeline Chong, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar 31. Date filed (Month, Day, Year) SEP 2 1 2004 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 15, Sheila Roberts Sept. 2004 7:42 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Hospital Center Cheverly P.G. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 💢 F 58 Director 090-38-2988 S.C Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or Iteme 23e or 28a-f ehow Examiner must be notified at 1 Yes 2 □ No MD. P.G. Landover Director the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2248 Brightseat Road #302 20785 U.S.A. death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 le marked other then "natural", or Item eny injury or other traumatic event, the Modical Examples ance. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille McCoy James Anderson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 2007 85 19a. Informant's Name/Relationship (Type, Print) Joseph L. Boone/Husband 2248 Brightseat Rd. #302 Landover, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation, 5 Other (Specify) Glenwood Cemetery 9/23/04 Wash., DC 21. Signature neral Service Licensee Hackett's Funeral Chapel, Inc. 814- Upshur Street, N.W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imprediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an this certificate has autopsy 1 🗌 Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2( 28a. Nate of Injury (Month, Day Year) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Naturel 2 Accident 5 Pending To the massive after death, within 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide to the Hospitel 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ophnell Cumberbatch, M.D.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

8416 Central Ave. Landover, Md. 20785

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 22, 2004 Pear Nicholas Rizak, Jr. 3:03 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** <u>Civista Medical Center</u> LaPlata

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Charles 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Director 198-18-2016 80 Sept 17, 1923 Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exist in servinal be netified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7555 Chicamuxen Road 20640 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1942

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: to 1945 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nicholas Rizak, Sr. Katheryn Slifco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7555 Chicamuxen Road <u>Nevenka Rizak - Spouse</u> Indian Head, MD other 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) St. Michael's Cemetery 8/26/04 Listie, PA 21. Signature of Funeral Service licen - e 22. Name and Address of Facility Mulcahy Funeral Home 305 Central Ave. Central City PA 1 PA 15926 23a Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shopk, or heart failure. List only one cause on each line. Interval Between Onset and Death mmediate Cause (Final Physician Cardiac Asystole disease or condition resulting in death) Minutes /Medical Due to (or as a consequence of): **Examiner** Hypovolemia Sequentially list conditions, if any, leading to immediate 12 Hours Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last the attending physician and hed for use as the burial-transit Repair of Abdominal Aortic Aneurysm that the death certificate be executed 24 Hours Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical Atherosclerosis <u>ears</u> IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Rectal Cancer 24b. Were autopsy findings available prior to completion of cause of death? Advanced Age 24a. Was an autopsy 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No Cardiac Disease or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊋Yes 2 □ No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-47202 104 XU Ti 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON Rd. Ste 202 WALDORF SAHDEVIUD 3450 010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da **Physician** Michael S. Richter 18, 2004 1027 a September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Shock Trauma None If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1**⊠**M 2□F Director 132 01 3666 87 June 21, 1917 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3004 N. Ridge Road Apt. 402 21043 or Items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after XYes 2 ☐ No fYes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1943-45 'natural', White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event, Item Max New York City Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Police Department 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frank Richter Geneve Podgorski 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian I. Richter/Wife 3004 N. Ridge Road Apt 402 Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 9-20-2004 Catonsville, MD Metro Crematory ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Show 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONTACT GUNSTOT WOUND OF MEAD Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a nuneequariou of): Examiner burial-transit the death certificate be executed and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 200 3 Probably 4 Unknown Completed been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? death? 1 XYes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ▼ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 No this ieral Director: After thi filled in by the funeral 28a. Date of In ury

\*\*Month, ay Year\*\*

28b. Time of Injury April 28c. Injury

\*\*No Company A 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: Division Hospital or Attending 24 hours after death. SUBJELT SHOT SELF 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3000 4 NCV2 TH . 21PLA determined Homicide Hemis 4402 ELLICUTTCITY, MS To the Hospital within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME September 19, 2004 ess of person who completed cause of death (Item 23a) (Type, Print) 01 RIPPLE 111 Penn Street, Baltimore, Maryland 21201 NS legistrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 1 2004 Registrar

			Tor State Registrar	State of	Maryland / Dep. Ce	artment of H <i>rtificate of I</i>			iene <sub>eg. No.</sub> ? () () (,	29758
			Decedent's Name (First, Middle, Last)		1.2			2, Date of Deat Month	h Day Year	3. Time of Death
Į.	Physicia /Medic		Hatsue Schafer							04 2:00 a M
	Examin	_	4a. Facility Name (If not institution, give		ber)	4b. City, Town, or	r Location of Death		4c. County of Dea	th
			4423 Camilla Road				Nottingha		Baltimor	
	Funeral Director		5. Social Security Number 6. Sex 553-35-0676	M 200 F	7. Age (In yrs. last birthday, 79 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 20	Year) 9. Bir Co , 1925 Ja	thplace (State or Foreign buntry) apan
	pu ,		Usual Residence of Decedent		10c. City, Town or L	anation.				10d. Inside City Limits
	aryla show	_	10a. State 10b. County							1 Yes 2 No
	89-f	ecto	MD Baltimo:	re	Notting				0g. Citizen of What Co	
	with the	ă	10e. Street and Number			10f. Zip Code				
	s 23	eral	4423 Camilla Road	12 Was Dece	dent Ever in U.S. 13.	21236	Ispanic Origin? (Spe	acity Yes or No-	United Sta	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinal must be nutilised at ODGE.	by Funeral Olrector	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed For 1 Tes :  If Yes, Give Year or Da	ces? 2 No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White	
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7	giene giene grith	mo.	10		Owne	er				
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yla	Ment arked	ဥ	Unknown Nakagawa					akagawa		
Maryland	2 sho	1 8	19a. Informant's Name/Relationship (Ty						, City or Town, State, .	
	and leafth m 27 her tr		Mr. Wayne Schafer	/Husbai					, MD 21236 20c. Location - City or	
altimore,	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition  1 Burial 2 Cremation 3 F	emoval from S	cemetery, cre	osition (Name of matory or other place	CB)	Sep 21		
Ē	tmen tent:		* 4 □ Donation 5 □ Other (Specify)			ake Crema	-	2004	Beltsville	e, MD
Bal	Depar Depar Impor any ir		21. Signature of Funeral Service Licens		100686		n and Fun		ernatives Baltimo	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that ca ne cause on ea	used the death. Do not en ach line.	ter the mode of dyin	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	Par	Kinson's L	disease				6 URS
	/Medical Examiner		resulting in death)	Due to (	or as a consequence of):	house D	11/404-			11
П	CXAIIIIIei		Sequentially list conditions,	Home		reale v	iseise			142
_	ed sit	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	ur as a sonsequence of):					•
	and and if-tran	Examin	that initiated events resulting in death) Last	Due to (c	or as a consequence of):					
8760,	cate be executed physician and the burial-transit									
387	icate phys s the	dlcal		J						
9 xc	the death certific y the attending p ached for use as I	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy				23d. Date of de	livery
Вох	atter for u	clar	in the past 12 pronths?			⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> _	/		Month	Day Year
o.	at the de by the a tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	wn					
ds, P	es thi	by	Part II. Other significant conditions co	ntributing to de	ath but not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	bacco use contribute to es 2 No 3 □ P	o the cause of death? robably 4  Unknown
Ö	w requir been si should	Completed						24a. Was a	n 24b. Were a	utopsy findings available
Re	The lav	ш						autops	ry prior to med? death?	completion of cause of
ā		S	25. Was case referred to medical				26. Place of Deat			2 No
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o		n:T	27. Manner of Death	28a. Date o	of Injury 28b. Time		y at	-	ow injury occurred	37
<u>o</u>	Attending it death. ector: After by the fune	atlo	Matural 5 ☐ Pending 2 ☐ Accident investigation	(NOTE	h, Day Year) Injury		Yes 2 □No			
Division of Vital Records,	i i it e	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		of Injury - At home, farm, s ng, etc. (Specify)	reet, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
_	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C			best of my knowledge, dea asis of examination and/or in					
	o the ithin ( o the xmple	Mec	29b. Signature and title of certifier		1	29c. Licens	se number	2	9d. Date signed (Mont	th, Day, Year)
	F 3 F 8		Mulumel	Siene-	land 1	23	3551		9/2/11	2
	in		30. Name and address of person who c	ompleted cause	e of death (Item 23a) (Tune	Print)	1111		1010	,
	V			110 F	Rostly 5	O DR 1	4314, 6	stim	ne 21	237
	Sta	ite	31. Date filed (Month, Day, Year)	32.	egistrar's Signature	hand's	1.0			
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Please Type or Print in Blas andelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEPT 12:55 PM **Physician** 18 04 0 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HARFORD Hir orien If Under 24 Hrs. Date of Birth (Month, Day, Yeer) ff Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. 6. Sex **Funeral** Months Deys Hours 1□M 20 F Yrs. 214-14-227 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylend Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumstic event, the Medical Examinar must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director 11NG 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21000 OUT Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race American Indien, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 ☐ Widowed 4 Divorced Specify. Completed by Year or Dates: 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be To OW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) vpe, Print) 19a. Informent's Name/Relationship-(7) 20b. Place of Disposition (Name of cemetery, cremetory or other place) MI 20a. Method of Disposition

1 Burial 2 Cremetion 3 F
4 Donetion 5 Other (Specify) Date 20c. Location - City or Town, State 3 ☐ Removal from State hview Man 4-220 . Gardens 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility MD 21234. BIALTI MORE! 8800 HARFORD RD. EVANS FUNERALCHAPEL O Wen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence ot) edical Certification: To Be Completed by Physiclan/Medical Examiner or Attending Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes \_2 ☐ Ne 25. Wes cese referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 1 Yes 2 → No 2 ☐ ER/Outpatient 3 ☐ DOA 4☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗆 Inpatient this 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*Extifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License numbe 29d. Date signed (Month, Day, Yeer) 29b. Signeture end title of certifier of death (Item 23e) (Type, Print) 30. Name end address of person who comple ted cause cen

**DHMH 16 Rev 6/95** 

State

Registrar

Registrer's Signature

(Month, Dev. Year)

2 1 2004

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

SEP 2 1 2004

ELECTION OF THE PARTY OF

			For State Registrar			artment of Health a rtificate of Death		Reg. No. 004	29761
	Physic /Med	ical	Decedent's Name (First, Middle,     Naomi E. S  4a. Facility Name (If not institution,	mith	el	dh Cita Tana		er <sup>Da</sup> 16, 2004	
	Exami	ш	84 Far Corne	rs Loop	Age (In yrs. last birthday)	4b. City, Town, or Location of Sparks  If Under 1 Year   If Under 24		4c. County of Deat Baltimore	9
	Funeral Director		217-10-0414 Usual Residence of Decedent	1□M 2 <b>X</b> F	93 <sub>Yrs.</sub>	Months Days Hours	Min.  8. Date of Birth (Month, Day OCT. U	year 1910 May	ryland ryland
	ne Marylan Ba-f show	ctor		/A	Baltimore				10d. Inside City Limits 1 Yes 2 □ No
	ath with the 2 s 230 or 2	rai Dire	10e. Street and Number 1347 West 41s			10f. Zip Code 21211		10g. Citizen of What Co USA	untry?
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 Is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Evanties must be invitited at	d by Funerai Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	12. Was Deceder Armed Forces d 1 Yes 2 If Yes, Give Year or Dates		Was Decedent of Hispanic Origin of Yes, specify Cuban, Mexican, 1 ☐ Yes 2 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
Maryland 21215-0036	ed within 72 h /giene. er than "nat	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-40)	(Give	dent's Usual Occupation kind of work done during most o DO NOT use retired) aker	of working	16b. Kind of Business/I  Own Home	ndustry
ryland	12 should be filed within "h and Mental Hygiene." 7 Is marked other than "Iraumatic event, The Men	To Be (	17. Father's Name (First, Middle, La John Chester  19a. Informant's Name/Relationship	Joy		Anna	Name (First, Middle, Elizabeth	Summers	
e, Ma	t and 2 sl Health and Im 27 Is r ther traur		Cheryl Favazza	/ Daughter	8	ng Address (Street and Number of 4 Far Corners L	oop Sparks	, Md. 21152	2
Baltimore,	t. Pa thmen tant: ijury		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe  21. Signature of Funeral Service Lice	cify)	Pine Grov		-21-04	20c. Location - City or T Mt. Airy, M	
eg Eg	Departing Important and in any		· KX11	1		Ruck Towson Fu 1050 York Rd.			
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	aDue to (or a	line.	er the mode of dying, such as ca	rdiac or respiratory arm	est,	Approximate Interval Between Onset and Death
	rate be executed thysician and the burial-transit and the burial-tra	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Example of injury that initiated events resulting in death) Last	b. Due to (or a:	a cynsequence of):	mod			geary
7.0. DOX 00	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
	w requires that been signed b should be det	by	Part II. Other significant conditions	contributing to death	out not resulting in the un	iderlying cause given in Part I.	23e. Did tob 1 ☐ Ye	s 2 No 3 Prot	he cause of death?
Hec	The law ate has b page 2 s	e Compieted	25. Was case referred to medical	/	- /			prior to co death? 1 Yes	ppsy findings available mpletion of cause of
5 8	uling Phys	To B	examiner?  1  Yes No  27. Manner of Death  1  Natural 5  Pending  2  Accident investigati		ury 28b. Time of	Other	Death (Check only one on the property of the p	nce 6 Other (Specif	vi daughtai h
DIVISION	vital or Attencurs after death ral Director: lled in by the	Certification:	3 Suicide 6 Could not determine	building, e	jury - At home, farm, stre tc. (Specify)		City or Town,		
:	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	Aedicai	one)	hyelcium: To the best aminer: On the basis of and mapner st	n examination and/or invi	estigation, in my opinion, death o	lace, and due to the ca occurred at the time, da	use(s) and manner as si te and place, and due to	ated. the cause(s)
1		Z	29b. Signature and type of certifier	(/ Ny	mj	29c. License number <b>D000412</b>		d. Date signed (Month,	
	5		30. Name and address of person who	D112,M	death (Item 23a) (Type, F	OSLER DR., Sin			
	⊸ Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1	32. District 2004	rar's Signature	ed)			

ORIGINAL

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			1 - For State Registrer	State of Ma	aryland / Depa <i>Cei</i>	artment of H			ene	29763
	Physic		Decedent's Name (First, Middle, Last,     Tyrone	)		Stokes		2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, give Union Mem. Hosp:			4b. City, Town, or Bal	Location of Dead		4c. County of Deat	h
	Funeral Director		5. Social Security Number 6. Se 214–80–6134 Usual Residence of Decedent	M 2□F	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			nplace (State or Foreign untry)  Md.
	Maryland a-f show	tor	10a. State 10b. County Md. NA		10c. City, Town or Lo	cation timore				10d. Inside City Limits 1√2 Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 2937 E. Monument	Street		10f. Zip Code 2120	)5	10	g. Citizen of What Co	untry?
9600	be filed within 72 hours after death with the Maryland that Hygiene.  Idea Hygiene.  Idea of their than "naturel", or terms 23e or 28e-f show event, the Modical Examinar must be notified at	d by Funeral	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give X Year or Dates:	No	Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
21215-0036	filed within 72 Hygiene. ther then "net ent, the Medici	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation e <i>completed)</i> College (1-4or 5	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wo	rking	6b. Kind of Business/I  Hospital	ndustry
Maryland	should be file nd Mental Hy marked oth umatic event	To Be (	17. Father's Name ( <i>First, Middle, Last</i> )  Darums  19a. Informant's Name/Relationship ( <i>Ty</i>		okman 105 Mailio		Lo	me (First, Middle, Ma rriane	aiden Sumame) Stok	
	es 1 and 2 of Health ar fitem 27 is rother treu		Lorriane Stokes  20a. Method of Disposition  1 Xeurial 2 Cremation 3 A	Mother	2937 20b. Place of Dispo-	E. Monum	ment St.	, Baltimor	Ce, Md. 2.	1205
Baltimore,	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			re Cem. Name and Address March F.H		Ba	Baltimore, altimore, I North Ave	Md. 21202
W.	Priysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as	the death. Do not entered.  See 5'. S a consequence of):	er the mode of dying	, such as cardiad	c or respiratory arres	t,	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	hemosy	huge			
.O. Box 6	the death certifi y the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of the line  2 Fetal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year	
<u>α</u>	sign sign d be	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the un	derlying cause giver	n in Part I.		cco use contribute to t	he cause of death?
		e Completed	25. Was case referred to medical					24a. Was an autopsy performed	d? prior to co	opsy findings available impletion of cause of
of	ling Phys After this uneral dir	To B	examiner?	ospital: 1 📓 Inpatier 28a. Date of Injur (Month, Day	v 28b. Time of	3 DOA Other 28c. Injury a Work?	4 Nursing H	th (Check only one) ome 5 Residence 28d. Describe how	e 6 Other (Special injury occurred	<b>(y</b> )
-=-	2552	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc				City or Town, S	·	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	one)	icien: To the best of er: On the basis of and manner star	of my knowledge, death examination and/or invited.	occurred at the time estigation, in my opin	, date and place, nion, death occur	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	vitt To Con	Σ	· WC ISSUE	6. N	10				Date signed (Month,	
	4		30. Name and address of person who con Ali Esmuili Zoi	East Park	way Buit	inore, M	02121	8-2895		
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 2 1 20	32. Re listra	r's Signature	harle				

		1 - For Amend Item # Registrar  1. Decedent's Name (First, Middle, Last,		Certifica	te of Death	Reg.	No.	3. Time of Death
Physicia	_		LINWOO.	A TA:	1 =1	Month SEPTEMBER	Day Year	
/Medic Examin	_	4a. Facility Name (If not institution, give			y, Town, of Location of Deat		4c. County of Dea	
LAdiiiii	.e.	JAINT AGNES HY	ALTHCARE	BA	LTIMORE, N	DN	BALTI	MORE
uneral irector		20-20-1038	7. Age (In yrs. In	Yrs. If Und Month	er 1 Year   If Under 24 Hrs s Days Hours Min.		9. Bi	rthplace (State or Fore
AC II		Usual Residence of Decedent  10a. State 10b. County	10c. City	r, Town or Location				10d. Inside City Lim
ortant: If item 27 is marked other then "naturel", or items 23e or 28e-f show injury or other treumatic event. It a Medical Evaninat must be notified at 9.	ctor	MARYLAND N	IA		BALTIMO	RE CIT	-4	1 (Yes 2 □ I
l be no	Director	10e. Street and Number	- N = - 20	T 018 101.2	Zip Code	0 / 10g.	Eitizen of What C	country?
ms 23	Funerai	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. Was Dec	cedent of Hispanic Origin? (S	specify Yes or No-	14. Race - Am	
, or Ite	by Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		pecify Cuban, Mexican, Puer 2/2 No Specify:	to rican, etc.)	Black, Wh	ite, etc.
aturel'	ed b	3 Widowed 4 Divorced  15. Decedent's Edu	Year or Dates:	16a. Decedent's Us	sual Occupation	168	. Kind of Business	LACK s/Industry
Medi:	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed)  College (1-4or 5+)	(Give kind of v	work done during most of wo use retired)	rking		·
t the	Соп	10THGRADE		131	ITCHER			MARKEI
even	Be	17. Father's Name (First, Middle, Last)		h. i. r.l	18. Mother E. Va.	zabeth Jol	den Sumame) <b>INSON</b>	- //  -
marke	٩	L RNEST  19a. Informant's Name/Relationship (T)	ne Print)	19b Mailing Addre	ess (Street and Number or Ri	SE ural Boute Number C	ty or Town State	Zin Code)
27 le r treu		BARBARA TALIFU	(WIFE)	1100	BOLTON ST.	APT. 818	BAMI	10.2120
fitem 27 r other tr	1 8	20a. Method of Disposition		lace of Disposition (A emetery, crematory o	lame of		. Location - City o	r Town, State
ant: If		1 ⊠ Burial 2 □ Cremation 3 □ F • 4 □ Donation 5 □ Other (Specify)	lemoval from State	T. Z10N	Comprey 09-	24-04 L.	4N5000	NE MARK
Important: If eny injury or once.		21. Signature of Funeral Service Licens	V. Willia	72 22. Name	and Address of Hacility	· BROW	JR.F.	YD 212
Ti		23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the death ne cause on each line.	. Do not enter the m	ode of dying, such as cardia			Approximate Interval Between Onset and Deat
sician ledical		Immediate Cause (Final disease or condition resulting in death)	SEPTIC Due to (or as a consequ	SHOCK				24 HOUR
aminer			· ·	TOPENIA				10 DAY
Ħ	iner	Sequentially list conditions, if any, leading to immediate cause. Liner dinderlying Cause (Disease or injury	Due to (or as a consequ	uence of):				
and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ					I MON
attending physician and for use as the burial-transit	calE		1	.55				
ng phy as the	Aedic	reservice V					1	
tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		pregnancy		23d. Date of de Month	alivery Day Year
the at	Physician/Medi	1 Yes 2 No	4□Pregnant at time of de 9□Unknown	eath 5 Other	(specify)		Worlds	Day Toal
ed by the detached	by Ph	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	g cause given in Part I.	23e. Did tobac	co use contribute t	to the cause of death
been sign should be						1 🗆 Yes	2 □ No 3 □ P	robably 4 Unkn
2 2	ompleted					24a. Was an autopsy	24b. Were a	utopsy findings avail
ate	Соп					performed 1 ☐ Yes 2 🔀		
certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	ath (Check only one)		
SO	To To	1 ☐ Yes 2 XNo  27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of	28c. Injury at	lome 5 ☐ Residence 28d. Describe how i		ecify)
itn. r: After thi e funeral	atior	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
arter deatn.  Director: A d in by the fu	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, fact	ory, office	28f. Location (Stree City or Town, S		Rural Route Number,
within 24 hours after  To the Funerel Directory completely filled in by	Medical C	29a. Certifier f  (Check only one)  (Check only one)  1 ★ Certifying Phy  2 ★ Medical Exeminates	sicien: To the best of my knowner: On the basis of examination and manner stated.	wledge, death occurr tion and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the caus arred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
o the	Mec	29b. Signature and title of certifier	and mannor stated.		29c. License number	29d.	Date signed (Mon	th, Day, Year)
> ⊢ ō		DONNA BILL	, MD OC	න් 0	P18607	SER	TEMBER	18,200
		30. Name and address of person who co		23a) (Type Print)				, , , , , ,
			HEALTH CARE		ATON AVEN			

DHMH 17 Rev 1/2001

IRVING TALLEY

Gertaude Tracey Baltimore, Maryland 21215-0036

1 - State Registrar	Certificate of Death	d Mental Hygiene
1. Decedent's Name (First, Middle, La		2. Date of Death  Month  Day  Year  7.36
er 4a. Facility Name (If not institution, giv	ve street and number)  (4b, City, Town, or Location of De	0 1 7 7 2001
Good Samar	Riton Hospital Baltimor	22
5. Social Security Number 6. S	Sex 7. Age (In rs. last birthday) If Under 1 Year If Under 24 F Months Days Hours M	drs. 8. Date of Birth (Month, Day, Year)  Southly State or County)
Usual Residence of Decedent  10a, State  10b, County	10c. City, Town or Location	10d. Inside City
	MORE Timonium	1 Yes 2
10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10e. Street and Number  10e. Street and Number  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No- 14. Race - American Indian,
11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ② No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	Black, White, etc.  Specify: White, etc.
15. Decedent's E	Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	Rott Co School
17. Father's Name (First, Middle, Last	t) 18. Mother's t	Name (First, Middle, Maiden Sumame)
P WILLIAM	n ( Stifler Mak	nel (.O. Hess
19a. Informant's Name/Relationship	(Type, Print)  19b. Mailing Address (Street and Nurkber or	Rural Route Number, City or Town, State, Zip Code)
20a. Method of Disposition	20b. Place of Disposition (Name of	Date c. Location - City or Town, State
1  Burial 2  Cremation 3  Control	Hemoval from-state	21-04 Blen Arm, MI
21. Signature of Funeral Service Live	22. Name and Address of Facility	ORKRD. Timonium mDZ10
23a, Part1, Enter the disease, or cor	mplications that caused the death. Do not enter the mode of dying, such as care	diac or respiratory arrest, Approximate
Immediate Cause (Final	y one cause on each line.	Interval Betwee
	PHADONODY (MKO)	CM
disease or condition resulting in death)	a. Due to (or as a consequence of):	SM.
resulting in death)	a. Due to (or as a consequence of):  Due to (or as a consequence of):	SM,
resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events	b	S.M.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	S'N),
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of):  c	S.M.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. 23c. If yes, outcome of pregnancy	23d. Date of delivery
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of):  c. — Due to (or as a consequence of):  d. —	SM.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. 23c. If yes, outcome of pregnancy    Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery
resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 20 No 9  Unknown  Part II. Other significant conditions	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.   23c. If yes, outcome of pregnancy 1	23d. Date of delivery  Month Day Ye
resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.   23c. If yes, outcome of pregnancy 1	23d. Date of delivery  Month Day Ye  23e. Did tobacco use contribute to the cause of deli  1 Yes 2 No 3 Probably 4 Un  24a. Was an autopsy findings a prior to completion of cau
resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.   23c. If yes, outcome of pregnancy 1	23d. Date of delivery  Month Day Ye  23e. Did tobacco use contribute to the cause of delivery  1 Yes 2 No 3 Probably 4 Un  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes  No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes  No	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.   23c. If yes, outcome of pregnancy 1	23d. Date of delivery  Month Day Ye  23e. Did tobacco use contribute to the cause of delivery  1 Yes 2 No 3 Probably 4 Un  24a. Was an autopsy performed?, 24b. Were autopsy findings an prior to completion of cat death?
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes No 9  Unknown  Part II. Other significant conditions  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes No	b	23d. Date of delivery Month Day Ye  23e. Did tobacco use contribute to the cause of delivery 1
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes No 9  Unknown  Part II. Other significant conditions  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes No	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify) 9   Unknown  contributing to death but not resulting in the underlying cause given in Part I.  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursin Work?  28a. Date of Injury   28b. Time of Injury   M   Work? 1   Yes 2   No    Death of Place of Injury   Al home farm street factory office.	23d. Date of delivery Month Day Ye  23e. Did tobacco use contribute to the cause of delivery Month Day Ye  24a. Was an autopsy performed?, 1 Yes 2 No  24b. Were autopsy findings an prior to completion of cat death? 1 Yes 2 No  Death (Check only one)  1 Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes No 9  Unknown  Part II. Other significant conditions  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes No	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 4   Pregnant at time of death 5   Other (specify) 9   Unknown  contributing to death but not resulting in the underlying cause given in Part I.  Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursin Work?  28a. Date of Injury   28b. Time of Injury   M   Work? 1   Yes 2   No    Death of Place of Injury   Al home farm street factory office.	23d. Date of delivery Month Day Ye  23e. Did tobacco use contribute to the cause of delivery 1
resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.   23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Ye  23e. Did tobacco use contribute to the cause of delivery Month Day Ye  24a. Was an autopsy performed?, 1 Yes 2 No 24b. Were autopsy findings any prior to completion of cat death? 1 Yes 2 No  Death (Check only one)  19 Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number City or Town, State)  ace, and due to the cause(s) and manner as stated.	
resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.   23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Ye  23e. Did tobacco use contribute to the cause of delivery Month Day Ye  24a. Was an autopsy performed?, 1 Yes 2 No 24b. Were autopsy findings any prior to completion of cat death? 1 Yes 2 No  Death (Check only one)  19 Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number City or Town, State)  ace, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)
SEP 2 1 2004

who completed cause of death (Item 23a) (Type, Print) 5601 LOCK

2. Registrar's Signature

Raven 21239

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year A M **Physician** 8:31 SIZVIAC 5017U20 PTIMBLRIB 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year 2183 SEWANES HARFORD DRIV If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
ALAGAMA 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Months Min. **5** M 2□ F Hours Yrs. Director 577-30-7043 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State itam 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic evant. The Modical Exprendial minist Le indiffied at 1 ☐ Yes 2X No Director FOREST HARFORD JOGAT 400 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ) RIVE H.Z. 2183 220 AC 25016 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ZITHU 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry  $\alpha$ e $\tau$ inu al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) BUDGET ADALYSIST FEORGLE CVEROPENT 137,62 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental and Mental LANG OKBET LAURA Grille 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31050 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State itam 27 l PARIA IAYLOG ORIVE FOREST HILL 3183 2WAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of I Important: If it any injury or or once. MBurial 2 ☐ Cremation 3 ☐ Removal from State P. BELAIR HIRI ( )ARYLAND ' 4 Donation 5 ☐ Other (Specify) 400E I MERIAL 21. Signature of Funeral Service Cicensee 22. Name and Address of Facility HARLE-GLAR, C -BILAIR, D.A. 1800 10. 2116T 23a. Part1. Enter the disease, or complicant his trat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLOUS A STATE OF CISCOSE **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown s been signed be should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Be Completed Atrial fibrilization 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 No or Attending Physician: funeral director 25. Was case referred to medical 26 Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aloese, MD 00045789 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) 2501 Ochunston St, APG MD 21005 R. Roese Ho 31. Date filed (Month, 2 1 2004 2. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryland		artment of He rtificate of D		ental Hygie	0001	29767
	Physici /Medic			mann				2. Date of Death Month Septembe:		4 0207 M
	Examir	ner	4a. Facility Name (If not institution, give a Carroll Hospital	Center		4b. City, Town, or L Westmi	nster	(	4c. County of Dea	ath
ì.	Funeral Director		5. Social Security Number 6. Security Number 220-30-1166	7. Age (In yrs. Ia	Yrs.	If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Oct 4 19)	ar) 9. Bi C 15 MD	rthplace (State or Foreign ountry)
	e-f show	ctor	10a. State 10b. County 10c Carroll	1	Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23e or 28	Funeral Director	10e. Street and Number 3830 Baker Road			10f. Zip Code 21157	-		Citizen of What C USA	<del></del>
020	permit. Pages 1 and 2 should be lied within 72 hours after death with rine maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The line 23e or 28e-1 show any injury or other treumatic event, the Medical Examinal must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
0-61212	o within 72 ha jene. Ir than "natu I're Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12		(Give life. L	dent's Usual Occupati kind of work done dui DO NOT use retired) okkeeper	on ring most of workir	ng	Kind of Business	vIndustry
ylalla	snould be filed ind Mental Hyges marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Ben Stoll				Charlot			
, Mai	and 2 sn ealth and m 27 is m ner treum		19a. Informant's Name/Relationship (Ty, Nancy Parks (daugh	iter)	607 H	g Address (Street and lammershir	e Rd., O	Route Number, Cit Wings Mil	y or Town, State, 1s, Md 2.	Zip Code) 1117
Dallillore	rages I ment of H ent: If ite ury or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ R 1 → 1 □ Donation 5 □ Other (Specify)	emoval from State	metery, cren	sition (Name of natory or other place) Valley Mem			Location · City or	
Da	Departing Departing Importer any injuries once.		21. Signature of Funeral Service License  Suan A.	Haight	1	Name and Address O. Box 19	Haig	ght Funera	al Home & 21784	& Chapel
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that daused the death. e cause on each line.  Call to sur)  Due to (or as a consequence)	Cefeuc	er the mode of dying,	such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death 24 HCS
,007	cate be executed by sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	,					
,	tending por use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery Day Year
L col	w requires man me de been signed by the a should be detached h	by	Part II. Other significant conditions con	tributing to death but not resul	ting in the un	derlying cause given	in Part I.	23e. Did tobacc		o the cause of death?
וו שפכר	siciali: The law requisions of the continuate has been irector, page 2 should	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
A IIC	dring Friystcian: The h.	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☑Inpatient 2 ☐ E	R/Outpatient	Othor	6. Place of Death	(Check only one)	6 □Other (Spec	cify)
	to the nospiral or Attending Fripsicality within 64 bours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes		8d. Describe how in	<del></del>	
	vome nospitel of Atlendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo		3 Suicide 6 Could not be determined	28e. Place of Injury · At hon building, etc. (Specify)				8f. Location (Street City or Town, Sta	ite)	
	within 24 hours To the Funerel completely filled	edical	one)	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time, estigation, in my opini	date and place, ar ion, death occurre	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
,	THE TO	M	29b. Signature and title of Gertifier			29c. License n	umber O4	29d. T	Date signed (Month	h, Day, Year)
	`		30. Name and address of person who co  ATR(CK LULAR  31. Date filed (Month, Day, Year)	mpleted cause of death (Item 2	417E /	02 / 1000	LIBERTY	BD EK	Asbus a	W 21784
	Sta Registr		SFP 2 1.20	14 Mariae	K A	race				/

		1 - For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Marylar		tificate of			Rag. No.	004	29768
Physicia /Medica	al	Thomas Franklin  4a. Facility Name (If not institution, give str	Troxell Jr.		Ab City Town		2. Date of Dea Month Septem	ber 1	2001	3. Time of Death 10:15p M
Examine Funeral	er	7200 Third Avenue  5. Social Security Number 6. Sex	C-133	last birthday)	4b. City, Town, or Sykesvil			Can	rro11	place (State or Foreign
Director		288-20-0341 TX N	<sup>1 2□ F</sup> 78	Yrs.	Months Days	Hours Min	8. Date of Birt (Month, Da Dec 18		PA	ntry)
Ba-f show	ctor	Md Carroll		kesvil						10d. Inside City Limits 1 XYes 2 No
23a or 2	Funeral Director	10e. Street and Number 7200 Third Avenue	C-133		10f. Zip Code 21784			10g. Citize USA	n of What Cou	ntry?
Paris	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	. Was Decedent Ever in to Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐XNo	ispanic Origin? ( In, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White, Decify: whi	etc.
r than "netu	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired Vestment	during most of wo l)	orking	16b. Kind	of Business/In	dustry
Importent: If item 27 is marked other than any njury or other traumatic event, Ital Mannes.	To Be C	17. Father's Name (First, Middle, Last) Thomas F. Troxell				18. Mother's Na		Chas	se	
em 27 ls m ther traum		19a. Informant's Name/Relationship (Type Hyla A. Troxell (spe 20a. Method of Disposition	ouse)	7200 S	ng Address (Street a $\Gamma$ hird $Ave$ sition (Name of	. C-133		11e,		84
rtent: If it njury or o		1  Burial 2  Gremation 3  Rer 4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licensee	noval from State	.1 Coun	natory or other plac ty Cremat	ion 9-20	0-04	Sykes	sville,	Md
any once		Page Haight		I P	. Name and Addres	95 Sykes	sville, M	1d 217	Home & '84	Chapel
sician ledical aminer		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the dea cause on each line.  Due to (or as a consec	MAT	er the mode of dyin	g, such as cardia		rest,		Approximate Interval Between Onset and Death
hysician and he buriat-transit	dical Examiner	Sequentially list conditions, day leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec							V
for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of a 9□Unknown	al death 3	Ectopic pregnancy Other (specify)			23d	I. Date of delive	ery Day Year
be d	þ	Part II. Other significant conditions contri	buting to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	/		ne cause of death?
	Completed						24a. Was a autop perfor	sv 🖯	prior to cor death?	psy findings available impletion of cause of
this c	Certification; To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hos  27. Many rol Death 1  Natural 5  Pending investigation 3  Suicide 6  Could not be determined	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h		28c. Injury Work M 1 🗆 Y	er: 4 🗋 Nursing i	28d. Describe h	ence 6 ow injury of		v) I Route Number,
To the Funerel Director; A completely filled in by the fo	edical Cer	Check only   2   Medical Examine	ian: To the best of my kn	owiedge, death	occurred at the time	e, date and place	and due to the c	21120(5) 221	d manner as st	ated.
To the complet	Med	29b. Signature and title of certifier	and manner stated.	MD	29c. License				igned (Month, a	
18		30. Name and address of person who com FLAVIO KRUTER M.D			Print) T., WESTM	INSTER	MD 21	157		
Stat Registra		31. Date filed (Month, Day, Year) SFP 2 1-200	32. Pagistrar's Sign		land to					

			1 - State Registrar	partment of Health and N ertificate of Death	Mental Hygie	2001 00000
ı	Physici /Medio Examin	cal	Anna Elise Reinhardt Tamburo      An Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		Day 2004 Sear 3. Time of Death 6:16p M  4c. County of Death
	Funeral Director		Golden Crest Assisted Living  5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	Westminster  If Under 1 Year   If Under 24 Hrs.  Months   Days   Hours   Min	8. Date of Birth (Month, Day, Ye	Carroll  9. Birthplace (State or Foreign Country)
	D	stor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Md Carroll Westmi		Nov 23 19	13 Md  10d. Inside City Limits 1 □ Yes 2 No
	th with the 23a or 28	al Director	10e. Street and Number 811 Fairfield Avenue	10f. Zip Code 21157		Citizen of What Country?
1036	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show deal Examinational be molfited at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give A Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
9500-61212	be filed within 72 hours after death with the Marylan lat Hygiene. Id other then "natural", or Items 23a or 28a-1 show event, The Medical Examilian mush by molified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) groc	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)  ery store owner		. Kind of Business/Industry
yland 2	should be file nd Menta! Hy markad oth	To Be	17. Father's Name (First, Middle, Last) Phillip Reinhardt	Marian	ne (First, Middle, Maid Hughes	
е, маг	ss 1 and 2 should I of Health and Meni item 27 is markar other traumatic		Christina Todd (daughter) 6006	Snowdens Run Rd.,	Eldersbur	g MD 21784
Baitimore,	Pages nent of ant: If it			rematory or other place) ew Memorial 9-20-	200.	kesville, Md
ğ	permit. Departing Importa		> Buan & Hunt	P.O. Box 195 Sykes	ville, Md	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that clused the death. Do not a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	las Accestent Peratri Viscola		Approximate Interval Between Onset and Death
8/60,	ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	eratic Viscola	- distas	25ys
O. Box 6	death e atter d for u	Physician/Me		3 ⊟Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
ras, P	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?  2 ▼No 3 □ Probably 4 □ Unknown
аі жесога	The law ate has b page 2 st	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
r Vital	Physician: this certific al director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpat	Othor	th (Check only one) ome 5 \(\subseteq\) Residence	6 XiOther (Specify)
DIVISION OF	ding I h. After funer	ertification;	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	of 28c. Injury at	28d. Describe how in	
2	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	0	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, Sta	
	he Hosp in 24 ho he Fune pletely fi	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, de 2 Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
	1	W	29b. Signature and title of certifier  July W. Smildleth mid Cos	29c. License number  25-443		Date, signed (Month, Day, Year)
	W O		30. Name and address of person who completed cause of death (Item 23a) (Typ John W. M. A. L. Etm. C. S. Pacife.  31. Date filed (Month, Day, Year)  32. Registrar's Signature	D 25443 Rd, Wistmi	nskr	m D 21157
	Sta Registr		32. Heatra's Signature	Landie		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 04 ear **Physician** HILDA Sept. THIERGARNER 20:00р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Univ. of Maryland Medical Syst Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 □ XF Director 213-01-7925 1/5/1912 Baltimore, MD Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 7 is marked other than "netural", or Iteme 23e or 28e-f show treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☒ No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8399 Bodkin Avenue 21122 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Salesperson/Teacher</u> Singer Sewing Machine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ss 1 and 2 should be fi of Health and Mental H item 27 is marked ot Unk Shipley Effie Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll W. Thiergarner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of He
Important: If iter
any Injury or oth Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery | 9/22/04 Elkridge, MD 22. Name and Address of Facility Stallings Funeral Home, PA 21. Signature of Funeral Service L 3111 Mountain Rd. Pasadena, MD 21122 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe Immediate Cause (Final disease or condition resulting in death) Onset and Death Subdural Hematoma Secondary to fall **Physician** /Medical Due to (or as a consequence of): Examiner budge M. Ver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER this certificate has been signed by the ettending physician and al director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be exe P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Wes decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4☐Pregnent at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. δ 1 Yes 2 No 3 Probably 4 Unknown Completed Was autopsy performed? 24a. Was an 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) t Yes Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 15/04 1 Natural 5 Pending 11:30 a<sub>M</sub> 1 ☐ Yes 2 ☐ No investigation 2X Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number. 83<sup>cg/gr Teyro</sup> and Number or Rural Route Number. 83<sup>cg/gr Teyro</sup> and Number of Rural Route Number. Md 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Home Yell Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 16234 29d. Date signed (Month, Day, Year) Sept. 16, 2004 Wuth 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)
Stephanie L. Davis MD, 22 S. Greene St, Baltimore, Md 21201

Registrar

State

31. Date filed (Month, Day, Year)

SEP 2 1 2004

Marie D. Spark

32. Registrar's Signature

			State of Maryland / Department of Health and M	lental Hygie	ne	
			1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death	7004	3. Time of Death
	Physicia /Medic	al	Floyd F Thomas	Month o	200	4 1/19 AM
	Examin	er	4a, Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Ab. City, Town, or Location of Death  Point March		4c County of Dea	Me Citil
T	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign
	Director	į.	Usual Residence of Decedent	kine 12, 1	960 11	Acyland
	arylan show	7	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 Yes 2 □ No
	r 28a-f	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What C	,
	ath witles		1330 N. Fremont AUE 21217		(15A	
936	hours after death with the Maryland tural', or Items 23a or 28a-f show al Exactinat must be collited at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ⋈ No If Yes, Give 1 □ Yes 2 ⋈ No If Yes, Give 1 □ Yes 2 ⋈ No If Yes, Force 1 □ Yes 2 ⋈ No If Yes, Sive 1 □ Yes 2 ⋈ No If Yes, Sive 1 □ Yes 2 ⋈ No If Yes, Sive 1 □ Yes 2 ⋈ No If Yes, Sive 1 □ Yes 2 ⋈ No If Yes, Sive If Yes, Specify: Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	72 hours "natural", dical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)	ng 16t	. Kind of Business	/Industry
2121	i within liene. r than "	omp	Elementary/Secondary (0-12) College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)			
pu	be filed within 72 ho Ital Hygiene. od other than "natur event, Ine Medical	Be		(First, Middle, Main	den Sumame)	
Maryland	d 2 should be th and Mental 7 is marked of traumatic ev	ဥ	19a. Informant's Narge/Relationship (Type, Print)  19b. Mailing Address (Bireet and Number or Rura	I Route Number, Ci	tv or Town. State.	Zio Code)
	and 2 s lealth ar m 27 is her trau		Shirkey Wilburn 1904 P. MORROE	Street-	Balline	re MARyland
Baltimore	of H fite		20a. Method of Disposition  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of certified and certifi	Plate 200	Location - City or	Two, State
Balti	pernit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  NAME of M. WALLAC  3405 C. Franklin		AL SORU	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or hear allure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between
	Priysician /Medical		Immediate Cause Winal disease or condition resulting in death)			Onser and Death
	Examiner		Du to (or as a consequence of):			500115
	ed sit	niner	Sequentially list conditions, It is you want to man adult to cause. Enter Underlying Cause (Disease or injury			memor
o,	ate be executed hysician and the burial-transii	Examine	that initiated events c. T V resulting in death) Last Due to (or as a consequence of):			UINI CUI)
8760		dical	d			
Box 6	eath certific attending p	0	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	livery
O. B	The law requires that the death certific ite has been signed by the atlanding p age 2 should be detached for use as	Physician/M	in the past 12 months?  1		Month	Day Year
s, P.	es thet i igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ord	w require been si should b			1 Tes	2 □ No 3 □ P	obably 4 Unknown
Vital Record	The law ate has b page 2 s	Completed		24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
ital		BeC	25. Was case referred to medical examiner? 26. Place of Death	(Check only one)	No 1 □ Yes	2 □ No
of V	Phys this ral dir	၉	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Hon	ne 5 Residence 28d. Describe how in		cify)
ion	inding ath. rr: After	ation	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury 4 Work?  1 Yes 2 No		nary cocarrou	
Division	ial or Attending PP s after death. al Director: After the ed in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St		ural Route Number,
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause	e(s) and manner as	stated.
	the Hin 24 the Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.  29b. Signature and title of certifier  29c. License number			
)	7.0 Wil		Seron Lattall P15750	290.	Date signed (Mont	2004
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Savan Fia Hali 20 S. Greene Street Battimane M	10 212	01	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 1 2004			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** AMEET GOPINATH TASKAR 9:55am M September 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Bethesda Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 M M 2□ F Country) India 37 Yrs **Director** 216-15-1312 Oct. 3, 1966 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If them 27 Is marked other than "nature" 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Montgomery 1 Yes 2 No North Potomac Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12443 Falconbridge Drive 20878 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gopinath Taskar Vijaya Bhise ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12443 Falconbridge Drive, North Potomac, MD 20878.

a of Disposition (Name of 20c. Location - City or Town, State Padmini Taskar (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Balt./Wash. Crematory Sept. 18, 2004 Laurel, Maryland \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. 21. Signatore of Funeral Service Licen M01250 7601 Sandy Spring Road, Laurel, Maryland 20/07 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Malignant Oligodendroglioma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 Tyes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient Certification: To 1 ☐ Yes 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death. 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D-27660 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w MD Alpana Goswami 11119 Rockville Pike, Rockville, Maryland 20852 31. Date filed (Month SEP) 32. Resistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

low to food

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #31 PER DVR G835 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 19, 2004 **Physician** 2:30 PM Ida A. Tagliavia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death Examiner 602 Knollcrest Place Apt E Baltimore Cockeysville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 1, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 □ M 2X F 220-14-3204 78 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f ahow other traumatic event, the Medical Exeminar must be notified at 1 ☐ Yes 2 ☐ No Cockeysville Director Md. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21030 USA 602 Knollcrest Place Apt E Items 23a death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 N No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Item any injury or other traumetic event, the Medical Exert 1X Never Married 2 ☐ Married 1 Yes 2 No Specify.White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Wrapper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Theresa Anania Tagliavia Carmelo 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 602 Knollcrest Place AptE Cockeysville, Md. 21030 Carmella M. Lanzo/ Sister 20b. Place of Disposition (Name of crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 9-22-04 Dulaney Valley Mem. Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a construence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner ro the Hospital or Attanding Physician: The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): Box 68760, physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 NO 3 ☐ Probably 4 ☐ Unknown 1 Tyes Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1. Natural 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. tha within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 1200

DHMH 17 Rev 1/2001

Registrar

6601 N.

person who completed cause of death (Item;

Date filed (Month, Day, Year SEP

r<sup>int)</sup>Charles St. Baltimore, Md. 21204

		1 - For Amend Item #	/ per Hos	9/21/0	d tas Certifica	e of D	eath		Reg. No	2004	2977
		1. Decedent's Name (First, Middle, Las	)					2. Date of Month	Death Da	y Year	3. Time of Death
hysici		Ala taliya	A. \	lound	e Va			SEP	17	2004	12:45 p
/Medio Examin		4a. Facility Name (If not institution, give	street and number)	0		Town, or L	ocation of De	eath	4c	. County of Deat	h
	Ŭ.	9551 Standon Plac	9			umbia				Howard	
uneral		Social Security Number     6. Se	х 7. Age ⊐м 2ДГ <b>64</b>	(In yrs. last birti	nday) If Under	r 1 Year Days	Hours N	lin. (Month,	Day, Year)	9. Birti	hplace (State or Fore untry)
rector		214-67-2669 Usual Residence of Decedent		05	15.			Nov 1	3, 19	39 Rus	ssia
*	1	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Lin
ole a	ō	MD Horroad		Colum	hia						1 ☐ Yes 2 🔀
28a-	Director	MD Howard  10e. Street and Number		COTO		p Code	-		10g. Ci	tizen of What Co	untry?
8 0	0	9551 Standon Pla	ce			045			Ukı	raine	
ns 23	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was Dece	dent of His	panic Origin?	(Specify Yes or	No-	14. Race - Ame	
Te T	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉	No				uerto Rican, etc.)		Black, White	e, etc.
0,1	þ	3 ☐ Widowed 4 XDivorced	If Yes, Give Year or Dates:		1 🗆 Yes	2XI No	Specify:			Specify: W	hite
atur.	Completed	15. Decedent's Ed		16 <b>a</b> .	Decedent's Usi (Give kind of w	al Occupat	tion	working	16b. K	(ind of Business/	Industry
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vent	Be (	17. Father's Name (First, Middle, Last)						Name (First, Mide			
rked tlc e	70	Abdula Battal	OV					ezhda	Sofi		
E U	Ι.	19a. Informant's Name/Relationship (7	ype, Print)					Rural Route Nui			Zip Code)
1.27 er tre		Elena Byrley - d	aughter				Place,	Columbia		21045	
oth		20a. Method of Disposition	Dommusi from State	20b. Place of cemeter	Disposition (Na y, crematory or	ime of other place	)	Date	20c. L	ocation - City or	Town, State
T. C.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 25 ☐ Other (Specify		Chesap	eake Cr	emato	ry 9/	18/2004		ltsville	
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Micrical Examinat natal building at once.		21. Signature of Funeral Service Licen	00		22. Name a	nd Address	s of Facility	Lohrmanı es Drive	<b>.</b>		
any ir	1	table	M	00986	18717°	reen	Pastur	es Drive	To	wson. MI	21286
		shock, or heart failure. List only	plications that caused	the death. Do n	ot enter the mo	de of dying	, such as car	diac or respirator	y arrest,		Interval Between
sician		Immediate Cause (Final	5110 04030 011 0401 III								Onset and Death
ledical		disease or condition resulting in death)		st Cance a consequence							1 year
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	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):						
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an an rial-tr	EX	resulting in death) Last	Due to (or as	a consequence	of):						
physicia the bu	dicai	•	d								
as th	edi										
attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1∏Live birth	of pregnancy 2 Fetal death	3 □Ectopic	pregnancy				23d. Date of del Month	livery Day Year
e att	sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at 9□Unknown		5 Other (				- il.	MORE	Day Toal
by the tached	hys	9 Unknown						· · · · · · · ·			
igned b	by P	Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlying	cause give	n in Part I.				the cause of death
C CO								_	☐ Yes 2	5 M vo 3 □ bi	obably 4 Unkn
S C/	Completed				<u>-</u> .			24a. W	as an utopsy	24b. Were au	topsy findings avail- completion of cause
page 2	Eo							1 ☐ Ye	erformed?	death?	2 □ No
certificate rector, pag	0	25. Was case referred to medical					26. Place of	Death (Check on			
S 0	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatie	ent 2 ER/Ou	tpatient 3 0	Othe Othe	or: 4 🗆 Nursir	ng Home 5 XP	esidence	6 □Other (Spe	cify)
를 교		27. Manner of Death	28a. Date of Inju		Time of njury	28c. Injury Work	at ?	28d. Descri	be how inju	ury occurred	
r: After e funer	Certification	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	M		res 2 □ No				
arrer dearn. Director: A in by the fu	ific	3 Suicide 6 Could not b	ZOO. FIACE OF IT	jury - At home, fa	rm, street, facto	ory, office			n (Street a Town, Stat		ural Route Number,
Direct of the by	ert	4   Monticide	Duliuling, e	ic. (Specify)				0, 0			
9 9		29a. Certifier 1 Certifying Pt	ysician: To the best	of my knowledge	, death occurre	d at the tim	e, date and p	lace, and due to	the cause(	s) and manner as	s stated.
⊙ <b>9</b> ii	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner st		d/or investigation	n, in my op	oinion, death o	occurred at the tir	ne, date ar	nd place, and due	o to the cause(s)
e Fune	1	29b. Signature and title of certifier		0	2	9c. License	number		29d. Da	ate signed (Mont	h, Day, Year)
within 24 hol To the Fune completely fi	Σ	1 1 7	. //	d						lander.	
within 24 hours after deati To the Funerel Director: completely filled in by the	2	Mr. PC	LL VOAL			1)( 9	1 4	Andrew Control	7	11710	/
within 24 hol  To the Fune  completely fi	/	30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print)	DS 9	378	3	7	117/04	/
within 24 ho  To the Fune  completely fi	/	30. Name and address of person who 6410 Rockledge	Drive, Su	death (Item 23a) ite 625 rar's Signature	(Type, Print) Bethes			317	17	11710	/

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JOCELYN HYNSON VARINA 2004 September 15, 9:30A /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3900 North Charles Street, Baltimore City
If Under 1 Year | If Under 24 Hrs. #404 N/A 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□ M 20 F Months Hours Min Yrs. Director 213**-**44-7927 90 May 5, 1914 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Itema 23a or 28a-f ahow Tre Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director N/AMaryland Baltimore City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3900 North Charles Street, #404 <u>21218</u> Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed withIn 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene. 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Technical Writer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be pe Charles 2 Hynson Ann Doggett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a litem 27 li r other tra Barbara Shepherd (Niece) 2004 LeDroit, South Pasadena, \_California 91030 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ō permit. Pages Department of Important: If It any injury or c 1 Burial 2 Cremation 3 Removal from State 4 □Donetion 5 □ Other (Specify) Bethel U. Meth Ch Cem 9/24/2004 Lively, Virginia 21. Signature of Funeral Service Licensee

Martin D. Lawson 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.

Paltimore Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death My a (archal exteret Immediate Cause (Final **Physician** Call disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ne The law requires that the death certificate be executed Exam attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐ Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown م Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ been si 1 Yes 2 No 3 Probably 4 dunknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 2 □ No 1 ☐ Yes 2 2 No 1 TYes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3□ DOA this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Issam E. Cheikh, M.D. 201 E. University Pkwy, #512, Baltimore, MD 21218 31. Date filed (Month, Day, Year) SEP 2 1 2004 32. degistrar's Signature State

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day TISPM Harold Williams eptember 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore 7. Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 239-46-992 Usual Residence of Decedent 1 M 2□ F 10d. Inside City Limit 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Himore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Vas Decedent Ever in U.S. Armed Forces? MYes 2 □ No Was Decedent of Hisp If Yes, specify Cultan, 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No f Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4er 5 Elementary/Secondary (0-12) Federal Government Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rucal Route Number, City or Town, State, Zip Code, 20b. Place of Disposition (Name illiams(WiFe) 20a. Methed of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart seture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration pneumonia Due to (of as a consequence of): Mulfisystom Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

permit. Page Department o Important: If any injury or once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral', or items 23a or 28a-f show Examiner must be notified at

. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other then "natural", or ite other traumatic event, the Medical Examina.

Baltimore, Maryland 21215-0036

Funeral Directo

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Completed

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physician and s the burial-transit attending pl ed by the a certificate has b irector, page 2 sl After this funeral of Director: /

the Hospital or Attending Physician: The law requires that the death certificate be executed

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hin 24 hours a the Funeral D

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Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical þ Completed Be ပ Certification:

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 TYes 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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september 17, 2004

State Registrar

DHMH 17 Rev 1/2001

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old court

SEP 2 1 20

31. Date filed (Month, Day, Year)

Randalls town, Manyland

- MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryjoy Mejig, MP

32. Registrar's Signature

Road

lap		1- State Unpend Item	State of 23a&27 p	Maryland/[ per me G83	Depai	rtment of He	ealth and M Ceath	lental Hy	giene		20777
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Examine		4a. Facility Name (If not institution, giv SAINT AGNES HOSPI	TAL			4b. City, Town, or L BALTIMORE	E CITY		<del></del>	ity of Death	
Funeral Director		5. Social Security Number 6. S 214-64-8623 Usual Residence of Decedent	Sex 7. I □ X M 2 □ F	Age (In yrs. last bir	thday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 12-9-	ay, Year)	9. Birthp Coun	lace (State or Foreign try)  Md.
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je 22 21 11 1	by Funeral	2532 Cheshire Di  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	ent Ever in U.S. es? No	lf '	21244 as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe	ocify Yes or No Rican, etc.)	- 14. R	SA ace - Americ ack, White, o	
und 21215-0036 be filed within 72 hours after tal Hygiene. Indouble than "natural, or lie event, the Medical Examine	Completed	15. Decedent's E. (Specify only highest gra			(Give ki life. D(	nt's Usual Occupation of work done dured NOT use retired)	on ring most of working	ng	16b. Kind of	Business/Ind	lustry
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or any injury or other traumatic event, the Madical Examples.		Darlene Y. Washin  20a. Method of Disposition  1 ₩ Burial 2 □ Cremation 3 □	ngton V	Nife 25 20b. Place of cameter	532 ( Disposil ry, crema	Cheshire ion (Name of tory or other place)	Drive Ap	t. A, E	Baltimo: 20c. Location	Ce Md	. 21244 wn, State
Baltin permit. P. Departme Important any injury		21. Signature of Funeral Service Licer  22. Part. Enter the disease, or com	Wané	>	22. M	el Cem. Name and Address arch F.H.	East :	Balt 1101 E.	Dunda imore, North	Md.	· 21202
876( cate be ohysicia the bur	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any, leading 15 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hypert Due to (or b. Due to (or c	as a consequence of	of): of):	osclerotio	c cardio	vascu1a	r disea		Approximate Interval Between Onset and Death
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To the Ho within 24 P To the Fu Completely	Medical	29b. Signature and title of certifier  30. Name and address of person who	and manner	s of examination and stated.	1/or inves	29c. License no	ion, death occurre	d at the time, d	date and place	and due to t	the cause(s)  ay, Year)
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		State of Maryland						•	•	
		1 - State Registrar		rtificati					g. No.2 () ()	29778
Dhuo	ioion	Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death
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Exan	niner			4b. City,	Town, or	Location of	f Death		4c. County of De	
		8401 Commercial Street  5. Social Security Number  6. Sex / 7. Age (In yrs. las	t hirthday)		Sava 1 Year	ge If Under 2	24 Hrs.	8. Date of Birth	Howard	<u> </u>
Funera Directo		215-80-8929 1DVM 2□F 45	Yrs.	Months	Days	Hours	Min.	(Month, Day,	Year) 1959 Ma	Birthplace (State or Foreign Country) arvland
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the M	Pote	Maryland Howard Sa	ivage	104 7%	Codo			14	) - Ohi 1144	
III.d. Z. I.Z. I. 3-0030 be filed within 72 hours after death with the Maryland Hall tygiene. d other then "natural", or items 23a or 28a-f show event, the Wedical Examinar must be notified at	Fineral Directo	8401 Commercial Street		10f. Zip 207					Og. Citizen of What (	_ountry?
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after or its				If Yes, spec 1 ☐ Yes :		n, Mexican, Specify:	, Puerto	Rican, etc.)	Black, Wi	nite, etc.
ural',	2	3 Widowed 4 Divorced Year or Dates:							Specify:	White
n 72 l	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usua kind of wor	il Decupa k done d	ation Ju <i>ring m</i> ost )	of work	ing	16b. Kind of Busines	is/Industry
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Hyg other	A B	17. Father's Name (First, Middle, Last)				18. Mother	r's Name	(First, Middle, N		
should be filed with and Mental Hygiene. I marked other ther	L C	Herbert Whitehead	1			Min	nie	Wilson	1	
S S E E		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address	(Street a	and Number	r or Rura	l Route Number,	City or Town, State	, Zip Code)
r, ro		Debra Whitehead (Sister)  20a. Method of Disposition 20b. Plac		Box  sition (Nan		Sav	age,			
Pages nent of h		cem	etery, crei	matory or or	ther place	9)   1 Car			0c. Location - City o	ttsville,Md
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ding P	2	27. Manner of Death 28a. Date of Injury 28 (Month, Day Year) 2	3b. Time o Injury	M 2	8c. injury Work	at :? ∕es 2 ⊟ N		28d. Describe how	w injury occurred	
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al or safter	Certification.	4 ☐ Homicide determined building, etc. (Specify)						City or Town,	State)	
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7. wit	1	29b. Signature and title of certifier		290	. License	number	9	29	d. Date signed (Mor	ith, Day, Year)
<i>l,</i>		30, Name and address of person who completed cause of death (Item 2:	3a) /Tunn	Print)	7	2	1		pr. 20	2004
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ORIGINAL

Deborah Ward 04-06007 MAI

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			Registrar  1. Decedent's Name (First, Middle, Last			runcal	011	Death	2. Date of D	eath	111111	3. Time of Death
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			Union Memorial Ho  5. Social Security Number 6. Se		In yrs. last birthda	y) If Unde	Lt imc r 1 Year	If Under 24 Hr	S. 8. Date of B	rth	9. Birt	tholace (State or Foreign
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Maryli	-f sho	Į.	Maryland	N/A	Ва	1time	ore					1 X Yes 2 □ No
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ath wi	23a c		436 Fawcett Str					21211	(Consider Van en N		14. Race - Ame	
<b>d 21215-0036</b> filed within 72 hours after death with the Maryland Hyniane	id other then "naturel", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🔀 🗞 If Yes, Give Year or Dates:		If Yes, spe	cify Cuba	Specify:	(Specify Yes or N erto Rican, etc.)	0-	Black, Whit	
<b>5-0</b>	natur dical i	Completed	15. Decedent's Edi (Specify only highest grad		16a. Dec	edent's Usu ve kind of wo	al Occup	ation during most of w	orking	16b. Ki	ind of Business	/Industry
within	then be Me	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		memal		3)			In own	home
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours aff	is marked other raumatic svent, III	To Be Co	17. Father's Name (First, Middle, Last) McHenry W. Ying	gling	1				ame (First, Middl erine (			
Marylan 2 should be	or other traumatic		19a. Informant's Name/Relationship (7) Roby A. Ward,						Rural Route Num.			Zip Code) [D 21211
Teand Health	tem 27 other t		20a. Method of Disposition	il. ilus	20b. Place of Dis	position (Na	me of		Date		ocation - City or	
Baltimor permit. Pages Department of	Important: If Item 2 any Injury or other once.		X X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify  21. Sign   1 re of Funeral S   vice   cer	)		Hill	Cem	etery				nie, MD
Balt Permit.	any Ir		21. Sign pure of Funeral Strice (Cert	Oct W.		Burge 3631	ee-H Fal	lenss-S 1s Roa	eitz Fi	iner	al Hom re. MD	e, Inc 21211
			23a Part 1. Enter the disease, or com- shock, or healt failure. List only	ications that caused the								Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	ю.	ONAR				THE OLI			Onset and Death
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cuted	nd ransit	Examiner	that initiated events	c								
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68760	physis the	edlcai	•	d								
Records, P.O. Box 6: The law requires that the death certific	he attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 □ No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at til	Fetal death	3 □Ectopic p 5 □ Other (s		у			23d. Date of de Month	livery Day Year
P.C	signed by the a be detached f	Phy	9 € Unknown  Part II. Other significant conditions or	ontributing to death but	not resulting in the	underlying	cause giv	ven in Part I.	23e. Did	tobacco u	use contribute to	o the cause of death?
rds quires	n sign uld be	ed by							1 🗆	]Yes 2	<b>₽</b> N₀ 3□P	robably 4 ∏Unknown
Vital Records, slclan: The law requires th	has been si ge 2 should	Completed							24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
	pag	Com						ř	11€ Yes	formed? 2 \( \subseteq \text{No}	death?	s 2 No
of Vita Physician:	certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	aVICD/Outes	iont 200	Ott Ott	ner	eath (Check only		6 FlOther (See	noife)
P. P.	eral di	n: To	1 XYes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time		28c. Injui Wo		Home 5 Re 28d. Describe			эспу)
Vision	or: After	atlo	1 Natural 5 Pending investigation	1	Yea <i>r)</i> Injur	M		Yes 2 □No				
- h	within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, facto	ry, office			(Street an own, State		fural Route Number,
ldsoll et	n 24 nours al ns Funerel D bletely filled i	edical		ysician: To the best of niner: On the basis of e and manner state	examination and/or							
Tot	To the Complet	Ž	29b. Signature and title of certifier	L 18/ 00	10.0	25		se number			te signed (Mon	
			30. Name and address of person who	completed cause of de	ath (Item 23a) (Tur	ne. Print	U.C.	.M.E.		sep	rember	18, 2004
	10			KOREU -			enn S	Street,	Baltimo	æ, M	aryland	21201
		ate	31. Date filed (Month, Day, Year)	22. Registrar	's Signature							
DHMH	Regist	to e	SEP 2 1 2004	Believe	1. As	W						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September **Physician** 17, 2004 Clara Ann 3:00 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4303 Washington Street Halethorpe
If Under 1 Year | fl Under 24 Hrs. |
Months Days Hours Min. Baltimore 8. Date of Birth
(Month, Day, Year)
July 29, 1928 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 216-24-4535 1 M 2007 76 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No MD. Director Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 4303 Washington Street 21227 Completed by Funeral United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 25 Married Specify: White 1 Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Key Punch Operator State of Maryland other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth any injury or other traumatic event 9DC8. Be ပ Thales Pumphrey Grace R. Hawkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger W. Wigley Spouse 4303 Washington Street, Halethorpe, MD. 21227 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville Veterans Cem 09/20/04 Crownsville, Md, 21032 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors 21. Signature of Funeral Service License Moo333 8728 Liberty Road, Randallstown, MD 21133-4784 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ecum disease or condition resulting in death) wo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Wasan page 2 2 1 No Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After Injury | Natural 5 Pending 1 TYes 2 No death. investigation 2 Accident hours after deat ineraf Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide within 24 hours a To the Funeraf E 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Ste. 106, Glen Burnie Mb 1600 harles WyM.D. S. Croin Hos 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:25 A M WILLIAM Henry 09 17 2004 WEDRA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs. Director 213**-**20**-**1056 22, 1924 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f ehov other traumatic evant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 1 Colgate Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates: Specify. Completed by 3 XWidowed 4 ☐ Divorced WW II White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. 12 Fireman City Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wedra Katherine George (nmn) (nmn) Dittman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Collison - Sister 255 Pine Lane, Los Altos, California 94022-1646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 9/20/04 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pris /Medical Due to (or as a consequence of): Examiner usch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit reuple and Due to (or as a consequence of): the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown þ should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: page certificate 1 ☐ Yes 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 🗌 Inpatient 2 ☐ £R/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident the Diractor 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide .⊆ Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

SEP 2 1 2004 DHMH 17 Rev 1/2001

DAVID S. DUNN

31. Date filed (Month, Day, Year)

ORIGINAL

Registrar's Signature

MACPHAIL ROAD, BEL AIR, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

032255

September 18, 2004

			For State		•				Mental Hyg	000	11 .	00000
			RegistrarAMEND ITEM  1. Decedent's Name (First, Middle, L		r phy	goss'	9:24704	JHaiii	2. Date of Deat	g. No.	16	3. Time of Death
	Physicia		William Mars	,	rren,	Tν			Septembe	Day	Year 2004	12:00P M
	/Medic Examin		4a. Facility Name (If not institution, ga			JI.	4b. City, Town, or	Location of Dea		4c. County		12:00P
	_Aarriii.	Ŭ.	Smith's Eldercan	re			Edgewo	ood		Harf	ord	
Т	Funeral		Social Security Number     6.	Sex 7. Ag	ge (In yrs. las		If Under 1 Year Months Days	If Under 24 Hi		Year)	9. Birthpla	ace (State or Foreign
	Director		215-03-1565	ILM 2LIF	90	Yrs.			Nov. 20	, 1913	Mary	1and
	and and	}	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				10	d. Inside City Limits
	Mary -f sh	ţō	Maryland Harfor	ൻ	Be	l Air						1 Tyes 2 □ No
	r 28a	Irec	10e. Street and Number				10f. Zip Code		10	g. Citizen of V	Vhat Countr	y?
	th wit	a D	108 North Main S	Street			21014			USA		
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2	or it	by FL	1 Never Married 2 Married	1 XYes 2	No		I□Yes 2 XNo	Specify:	, ,	Specify		
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<u> </u>	should b nd Menta markad imatic e	2	William Mai	cson Wa	arren,	Sr.		Helen	Margue	erite	Во	wen
0	C1 42 72 92	1	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a	and Number or I	Rural Route Number,	City or Town,	State, Zip C	lode)
≥ 15	1 and Health em 27		Donald J. Kreine	er - POA E			Bonnie Av	renue, B				
5	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1    Burial 2 □ Cremation 3	Removal from State	сел	netery, cren	natory or other plac	·		20c. Location -	•	
	t. Pa tmer rtant ijury		*4 Donation 5 Other (Special Signature Line)	2	Bel		Mem. Gard			Bel Air	•	-
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00/00		dlcai		d		<i>y</i> c	PILWI	7 4	-			//· K
<b>Y</b>	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	:v				22d Date	of delivery	,
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corus,	en sie	ted	POST- PEAULIA	TIC ST	Ktss	54x	DRDMt		1 ☐ Yes	s 2 🗆 No	3 Probab	bly 4 🗹 Unknown
ב	a S S	Completed	HISTORY OF	Accordo	LISK	1_			24a. Was an autopsy	24b. V	Vere autops	sy findings available pletion of cause of
	The page	Con							perform	ed? d	eath? Yes 2	
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5	Phye this c	-T	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 ☐ Inpati		Outpatien 8b. Time of		4   Nursing	Home 5 ☐ Resider			HOME
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2	Atten deal octor	flca	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of In	jury - At hom	e, farm, stre	eet, factory, office		28f. Location (Stre		r or Rural F	Route Number,
5	ai or s after N Dire	Certification:	4 Homicide	building, e	tc. (Specify)				City or Town,	State)		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	Physician: To the best aminer: On the basis of and manner st	or examination	edge, death n and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occ	ce, and due to the car curred at the time, da	use(s) and mar te and place, a	ner as stat nd due to ti	ed. he cause(s)
	Nithin Fo the	Me	29b. Signature and title of certifier	- 2/0			29c. License	number	29	d. Date signed	(Month, Da	ay, Year)
			> Verfill	C. Vala	ao	M.	D DE	D1632	89 5	plem	ben 1	6,2004
	12/		30. Name and address of person who	completed cause of	death (Item 2	3a) (Type, I	Print) 7 16 HAR	FORDR	OAD FA	ISTON	UM	021047
	Sta		31. Date filed (Month, Day, Year)		rar's Signatur		als		•			
	Registr	ar	SEP 2 1 2004	Dener	10	pyo						

		1	For State Registrar AMEND ITE					Health and I Death	Mental Hy	giene Reg. No. 1) (		29783
П	Physicia	an	<ol> <li>Decedent's Name (First, Middle,</li> </ol>	Last)		<del>3037 7</del> ,	/ <del>29/04 0</del>	11.	2. Date of De Month SEPTEM	Day	Year <b>2604</b>	3. Time of Death
)	/Medic Examin		4a. Facility Name (If not institution, UNIVERSITY OF			center		or Location of Deat			ty of Death	
	Funeral Director			6. Sex 1 1 2 F	7. Age (In yrs. I 74		If Under 1 Yea Months Days		8. Date of Bi (Month, Di May 24	rth ay, Year) 1930	9. Birth	place (State or Foreign intry)
	death with the Maryland ms 23a or 28a-f show		Usual Residence of Decedent  10a. State 10b. County  MD Howard	1	10c. City	y, Town or Lo	cation		-			10d. Inside City Limits
	with the 3a or 28a	Funeral Director	10e. Street and Number 8282 Murphy Road	d			10f. Zip Code 2075	59	1	10g. Citizen of U.S.A		intry?
	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene americal characted other than "natural", or litems 23a or 28a-1 show aumatic event, the Marulcal Examinar must be notified at	by Funera	11. Marital Status  1 Never Married **Married** 3 Widowed 4 Divorced	Armed Fo	2 No 195	2   '	Was Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)		ack, White	
Maryland 21215-0036	within 72 hou ene. than "nature he Madleal E	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College ( 2 Year	1-4or 5+)	(Give life. L	dent's Usual Occi kind of work don DO NOT use retii ractor/F	e during most of wo ed)	rking	16b. Kind of R.A. Z		ndustry
and 5	ld be filed ental Hygi ked other Ic event, I	To Be Co	17. Father's Name (First, Middle, L Ira L. Zimmerman	ast)	1	1	· · · ·	18. Mother's Na Olive Ma	me (First, Middle ae Anken		ime)	
2	7 £ ~ 2	-	19a. Informant's Name/Relationsh Crystal G. Zimmi	in (Type Print) TRMAN / S	pouse	1	-	at and Number or R Road Fult			n, State, Zi 20 <b>7</b> 59	
Baltimore,	000		20a. Method of Disposition  XXBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp				sition (Name of matory or other p Church	Cem. 9/2	Date 2/2004	20c. Location		Fown, State Maryland
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	-y		0770 3	13 Talbo	ost Avenue	e Laure	l, Mary	land	20707
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury	a. Due to	SAR-CHI	- HY1		2941222		arrest,		Approximate Interval Batween Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to d.	(or as a conseq	uence of):						
O. Box 68	death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Feta nant at time of d nown	Ideath 3	□Ectopic pregnar □ Other (specify)	icy		I	Date of delivership	very Day Year
ds, P.	es pe	by	Part II. Other significant condition	ns contributing to	death but not res	ulting in the u	nderlying cause	given in Part I.		tobacco use co		the cause of death?
Il Records	The law ate has b page 2 s	Completed							24a. Wa auto per 1 🗆 Yes	s an 24topsy ormed?	prior to c death?	topsy findings available completion of cause of
on of Vital	Attending Physician: Thir death. ector: After this certificate ector, After the funeral director, pag	To Be	25. Was case referred to medical example?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date (Mo		EP/Outpatier 28b. Time o Injury	f 28c. In	other: 4 🗆 Nursing	Home 5 Res 28d. Describe			nfy)
Division	al or Attendir safter death. I Director: At d in by the fu	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 200. Flat	e of Injury - At h	ome, farm, sti fy)	reet, factory, offic	е	28f. Location City or To	(Street and Nur own, State)	mber or Ru	ral Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medicel	Examiner: On the	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in m	time, date and place y opinion, death occ	e, and due to the curred at the time	e cause(s) and i , date and place	manner as e, and due	stated. to the cause(s)
)	To # To # Y	W.	29b. Signature and title of certified	1	ASOICAL	(Z&S)\0		nse number 6683		29d. Date sign		n. Day. Year)
	20		30. Name and address of person		use of death (Iter	m 23a) (Type,	Print)	SET BAL	Thate	mo a	2120	(
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2	1 2004	Registrar's Signa	ature	Carles					ì

	1	For State Registrar				of Health and of Death	_ ,	g. No.2 11 11 L	29781
Physician /Medica	1	1. Decedent's Name (First, Middle, Las BROCKMAN ADAMS			Ab City Toy	un au acation of De		Day Year R 10, 200	4 8:10 A <sup>M</sup>
Examine		Ia. Facility Name (If not institution, give				wn, or Location of De NSVILLE	am	QUEEN AL	
Funeral Director	~ (	5. Social Security Number 6. Se		(In yrs. last birthday) 77 Yrs.		rear If Under 24 H		Year) 9. Bi	rthplace (State or Foreign Jountry)
p .	- 1-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	noation			172. 01	10d. fnside City Limits
a-f show		MD QUEEN AN	NE'S	STEVENSVI					1 ☐ Yes 2 🙀 No
or 28	5	10e. Street and Number			10f. Zip Co	ode	10	g. Citizen of What C	ountry?
be filed within 72 hours after death with the Maryland hall hygiene. Indicate then "natural", or items 23a or 28a-1 show event, the Medical Exertime meat be modified at Recommendated by Finneral Director.	S C	138 TANNER S POIN  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 MEYES 2 ☐ No If Yes, Give Year or Dates:	o 13.	2166 Was Deceden If Yes, specify 1 ☐ Yes 2  ▼	t of Hispanic Origin? Cuban, Mexican, Pu		14. Race - Am Black, Wh Specify:	
natu "natu	200	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual C kind of work of DO NOT use i	done during most of v	vorking	6b. Kind of Business	s/Industry
ZIZID-U	2	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ENTATIVE/S	SENATOR	FEDERAL C	COVERNMENT
Maryland Z1Z to 2 should be filed within th and Mental Hygiene. Z7 Is marked other than traumatic event, the Mary	0	17. Father's Name (First, Middle, Last) CHARLES LESLIE AD.		1,77,77		18. Mother's N	lame (First, Middle, Ma		V V STULL ST 1
MG 2 alth ar 27 is ritrau		19a. Informant's Name/Relationship (7 ELIZABETH SCOTT A		138 7	CANNER'	S POINT DI	Rural Route Number,	NSVILLE,	MD 21666
0 00		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify		20b. Place of Dispo cemetery, cre-	matory or othe	r place)		oc. Location - City o	
Baltimore, permit. Pages 1 a Department of Hei Important: If item any injury or othe	Ī	21. Signatur of Fund of Service Licen		2:	2. Name and A	Address of Facility			HOME, P.A.
Physician /Medical Examiner		23a. Part1. Enter the disease, or companies, or shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. P	the death. Do not ene.	_	f dying, such as card		st,	Approximate Interval Between Onset and Death
ate be executed use to executed use burial-transit he burial-transit	2	Sequentially list conditions, 1 a.y, Lauring to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
The Coulds, F.C. Box 00/00,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	nysician inieu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 10 ☐ Unknown	Fetaf death 3	⊒Ectopic pregr ⊒ Other (speci			23d. Date of de Month	ofivery Day Year
quires that n signed by aid be deta	È I	Part II. Other significant conditions of	entributing to death bu	t not resulting in the u	inderlying caus	se given in Part I.	23e. Did toba		o the cause of death? robably 4 DUnknown
II KECOLGS, The law requires t cate has been signe page 2 should be completed by	naidillon						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of s 2 \sum No
	0	25. Was case referred to medical examiner?	Hospital:		-5		eath (Check only one)		
_ > .2 0 [2		1 Yes 2 No  27. Manns of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day	nt 2 ☐ ER/Outpatier y 28b. Time o Year) In <sub>f</sub> ury		Injury at Work?	Home 5 Hesiden 28d. Describe how		9cify)
To the Hospital or Attending Physinic 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Salling Salling	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injubulding, etc.	ry - At home, farm, st. (Specify)	reet, factory, of	ffice	28f. Location (Stre City or Town,	et and Number or R State)	tural Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled in Medical Co.	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exern	rsician: To the best of iner: On the basis of and manner state	examination and/or in	h occurred at to	he time, date and pla my opinion, death or	ce, and due to the cau	se(s) and manner a e and place, and du	s stated. e to the cause(s)
To the within To the comple	2	29b. Signature and title of pertifier	un C_	, no		37 06 4	290	d. Date signed (Mon	
1214		30. Name and address of person who d	completed cause of de	path (Item 23a) (Type,		·	Stevens v	1	
State Registra		31. Date filed (Month, Day, Year) SEP 1 4 20	32. Jegistra		neelle	¥', '	,		

			For State Registrar		State o	of Maryla			rtmeni tificate			and M		Reg. No.	104	20	7.8.5
	Physici	an	Decedent's Name (First										2. Date of De Month	Day	Year		of Death
	/Medic		Ineresa 4a. Facility Name (If not in	Margar	et	Armsti	rong		4h City	lown or	Location of	of Death	9	4c Cour	nty of Death	CO	:40 <sup>M</sup>
	Examin	ier	Sacred	Her (	7	1	ital		C	100	bea	100	bi	A	lega	110	
	Funeral		5. Social Security Number	6. Sex	-1 1	7. Age (In y	rs. last biri	thday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Bin	th v Yearl	9 Billion	lace (State	or Foreign
- 1	Director		213-44-6334		VI 2 🙀 F		57	Yrs.	Mortus	Days	Hours	MIL.	Aug. 30	,1947	PA		
	and		Usual Residence of Deced	dent County		10c.	City, Towr	n or Lo	ation					***************************************	11	Od. Inside	City Limits
	Manyl f sho	ō	187 1	Iomoolod u			~~~~	ann	<b>.</b>								s 2 No
	r 28a	rec	10e. Street and Number	lampshir	е		Green	Spr.	10f. Zip	Code				10g. Citizen o	of What Coun	try?	
	h with	al D	HC-86 Box 3	31						26	722			USA			
	72 hours after death with the Maryland "natural", or items 23a or 28a-f show edited Evant not must be notified at	Funeral Director	11. Marital Status	12	Armed Fe	edent Ever in	n U.S.	13. V	Vas Deced Yes, spec	ent of His	spanic Ori	gin? (Spo	ecify Yes or No Rican, etc.)	- 14. A	ace - Americ		
36	or it	by Fu	1 Never Married 2		1 ☐ Yes If Yes, Gi	2 No			☐Yes 2		Specify:		,	Spe	rify:		
ő	tural'	q pa	3 Widowed 4 D	ocedent's Educa	Year or E	Dates:	160	Deced	ent's Usua	Occupa	tion				Business/Inc	ite	
15	_ 8 - 48	Completed	(Specify only	highest grade	completed)			(Give I	kind of wor OO NOT us	k done di	uring most	of work	ing	TOD. KING OF	Dusinessynic	ustry	
212	filed within Hygiene.	E	Elementary/Secondary (	0-12)	College (	(1-4or 5+)			Bookk	eepe	r			Engi	neerin	g Co.	
פו	al Hyg other	Be C	17. Father's Name (First, /	Middle, Last)								r's Name	(First, Middle,			9	
<u> a</u>	Menta	To	George Del	laut							The	resa	Margar	et Mas	cilak		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show army injury or other traumatic event, Ita Medical Evan est initial be invilited at any injury or other traumatic event, Ita Medical Evan est initial be invilited at any conce.		19a. Informant's Name/Re	lationship (Type	e, Print)								al Route Numbe			Code)	
G,	t and tealth om 27 ther to		Ronald G. An		t (hus	sband)	b. Place of				Gree	nspr	ing, W		n - City or To	um Cinto	
Jor	iges 1 nt of H : If ite or ot		1 Surial 2 ☐ Cren	nation 3 □Re	moval from		cemeter	y, crem	atory or ot	her place	9)	9/1	6/04				
Itim	it. Pa intmer intant njury		*4 □ Donation 5 □ C				rore	SLC	Glen emete	ry	e of Eacilit	-	-	Green	spring	, WV	
Ba	permi Depa Impo any ir		\-\\-		(			111	E T	n.	J. T.	McK	ee Fune	ral Ho	me Ham	р. Ц	LC.
	1000		23a. Part1. Inter the dise shock, in heart failur		alions that	caused the de	eath. Do r	not ente	or the mode	of dying	n la j, such as	cardiac o	omney, or respiratory ar	rest,	57	Approxim	ate
	Physician		Immediate Cause (Final	e. List only one	cause on	each line.	- ^	(							,	Onset and	d Death
	/Medical		disease or condition resulting in death)	a.	Due to	(or as a cons	sequence (	of):	771	uli	314	7 0 1	PATH	7		CHR	CNIC
- 1	Examiner		Sequentially list condition	e b.													
	A =	iner	Sequentially list condition cause. Enter Underlying Cause (Disease or injury	is J	Due to	(or as a cons	uence	nt):									
a	ecute and -trans	Examiner	that initiated events resulting in death) Last	c.	- Due to	(or as a cons	raguanea :	26):									
8760,	that the death certificate be executed by the attending physician and detached for use as the burial-transit	<u>e</u>	, , , , , , , , , , , , , , , , , , , ,		Due to	(UI as a COIIs	sequence	οι).									
387	phys phys s the	dicai		d.													
Вох 6	certifica nding pl	Physician/Mec	IF FEMALE: 23b. Was decedent pregn	ant 23	c. If yes, ou	utcome of pre	gnancy							23d. [	Date of delive	rv	
ă	death	iciai	in the past 12 month		4☐Preg	birth 2 ☐ F nant at time o			Ectopic pre Other (spe							Day	Year
P.O.	t the c by the	hys	9 □ Unknown		9□Unkr	nown											
	w requires that the s been signed by th should be detache		Part II. Other significant of				resulting in	the un	derlying ca	use give	n in Part I.		23e. Did to	obacco use co			
ord	equir sen si ould	ted	DIKPETE	(1 W	11:4	<u> </u>					<del>-</del>		101	′es 2□No	3 Proba	ably 4	Unknown
Division of Vital Records,	> 0	Completed by											24a. Was autop	sv	. Were autor prior to con	sy finding	s available cause of
	The sate h	Co											perfo	rmed? 2 <del>/∐N</del> o	death? 1 ☐ Yes	2□ No	
Vita	icien. Sertific	Be	25. Was case referred to examiner?		spital:	^				Otho		of Death	(Check only o	ne)			
of	Physical this cal dir	2	1 Yes 2 No 27. Manner of Death	10	1,00	-	ER/Ou	tpatient		dc. Injury	4 L Nu	-	me 5 Resid			)	
UQ.	ding h. After fune	tion	1 Natural 5 □	Pending investigation	(Mor	of Injury oth, Day Year	r) [1	njury	M	Work	? ′es 2 ⊟1		Edd. Describe i	iow injury occ	arred		
18.	Atten deat ctor: y the	fica		Could not be determined	28e. Place	e of Injury - A	t home, fa	rm, stre				_	28f. Location (S		nber or Rural	Route Nu	mber,
Ο̈́	after after	Certification;	4  Homicide	00(0)(1)(1)(00	build	ding, etc. (Spe	ecity)						City or Tov	m, State)			
	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funerel Director: After this certificate has completely illed in by the funeral director, page 2	edicai C	29a. Certifier (Check only one)	ertifying Physi edical Examine	or: On the b	e best of my basis of exam	knowledge nination and	death d/or inv	occurred a estigation,	t the time in my op	e, date an inion, deal	d place, th occurr	and due to the ded at the time,	cause(s) and r date and place	manner as sta e, and due to	ated. the cause	(s)
	To the within To the comp	Me	29b. Signature and title of	certifier	^					License				29d. Date sign			
			MUVX	-51		WO			D	54	756	5	<	FATE	MbER	14	2004
	15		30. Name and address of			_		Туре, Я	Print)	-			n law			-	
	17		DR. Kobe	-C+ KC	200	912	Ser	ar.	DRI	2	Cir	nbe	vani	), MI	>215	07	
	Sta Registr		SEP 2 0	2004	32.4	Registrar's Sig	griatura	we									

			1 For State	State of Mary				Mental Hyg	jiene		
			Registrer	<del></del>	Ce	rtificate of	Death		eg. Noi	nL.	20706
	Physici /Medic		1. Decedent's Name (First, Middle Robert	Wilson	Bake	r :	Sr.	2. Date of Dea Month	Day	Year 2004	3. Time of Death
	Examin		4a. Facility Name (If not institution,		,	4b. City, Town,	or Location of De			nty of Death	,
			Keninswa Kegio				Stury		Cuu	comic	D
	Funeral Director		5. Social Security Number 215-38-2300	6. Sex 1 ☑ M 2 ☐ F 7. Age (In	yrs. last birthday, Yrs.	If Under 1 Year Months Days			/1941	Coun	lace (State or Foreign try) 'Yland
	pum *		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Le	neation					
	death with the Maryland ms 23a or 28a-f show	tor		icomico	Salis						0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	of What Coun	try?
	23a o	ai D	1904 Nancy Av	7e.		218	804		U	SA	
	tems er o	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	Hispanic Origin? (	(Specify Yes or No-		ace - Americ lack, White,	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show amy jointry or other traumatic event, the Micdies Examiner out the notified at once.	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🔀 Divorced	ed 1 X Yes 2 ☐ No If Yes, Give Year or Dates:Ma1		1 ☐ Yes 2 🔼 No			Spec		white
5	72 hor	ted	15. Decedent'	s Education	16a, Dece	dent's Usual Occup	pation		16b. Kind of	Business/Inc	fustry
V	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of w	orking		-	
7	iled w Hygier ther ti		12 17. Father's Name (First, Middle, L			Air Fre		ame (First, Middle, I		ler J	ones
	d be fental liked of	To Be	Robert M. Ba	· ·			Ethe		mon	ame)	
	shou and M s mar umat	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Maili	ng Address (Street		Rural Route Number		n, State, Zip	Code)
Ž	and 2 salth a n 27 ls		Robert W. Bal		1904	4 Nancy	Ave.,	Salisbu			
alo	Jes 1 t of He If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	b. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce)	Date		n - City or To	
Dallillion	t. Pag tment tant: ijury		`4 ☐ Donation 5 ☐ Other (Sp	ecify) S		cy Crema	atory	/2/04	S	alish	ury, MD
0	Departing Department of the policy of the po		21. Signature of Funeral Service L	Censee		Name and Address	Funer	al Home	Prof	essio	nal Assoc
m			23a. Part1. Enter the disease, or o	complications that caused the				Rd., Sali		Y,MD	
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	111.	,	1. (	2. /		0 -		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a con	osclerose of):	oric L	ardiov.	ascu/4-	1)3.	_	Coyver
	Examiner	<b>.</b>	Sequentially list conditions,	b	I D	abeter	nell,	usalar bs			20405
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):						
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0/00,	cate be executed physician and the burial-transit	dical		d							
_		Med	IF FEMALE:								
ממ	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy	/			ate of deliver	y Day Year
į	uires that the death certificing signed by the attending does detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	or death 5	Other (specify) _					
٢,	s that	by Pł	Part II. Other significant condition	s contributing to death but not	resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use cor	ntribute to the	cause of death?
5	w require been sig should b		Hypertens	100				1 □ Ye	s 2 No	3 🗌 Proba	bly 4 🗌 Unknown
מ	e law ru has be ge 2 shi	ompieted	, v					24a. Was ar		Were autop	sy findings available ipletion of cause of
=	Physiclan: The I this certificate ha al director, page	Con						perform	ed?	death? 1 ☐ Yes 2	
N 110	iclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only one	)		
5	Phys r this ral dii	- To	1 Yes 2 No	1 Inpatient 2	2 ER/Outpatien 28b. Time of		4   Nursing	Home 5 Reside			
5	nding Phy th. r: After thi e funeral	atior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year	r) Injury	Wor	k? Yes 2 □ No	200. 0000,00 110	in inquity occu		
2	r Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin		At home, farm, stri	eet, factory, office		28f. Location (Str City or Town	eet and Num	ber or Rural	Route Number,
2	oital o urs aft oral Di								ĺ		
	To the Hospital or Attending Physician: The law requires that the death certify the Abours alter death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the tuneral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the best of my xaminer: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the ting restigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) and m te and place	nanner as sta , and due to t	ted. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date sign	ed (Month, D	ay, Year)
			1065.1	lino		02	4986		9/1/0	9	
ĮΔ	_		30. Name and address of person w		Item 23a) (Type,						
, ,	-61-		31. Date filed (Month, Day, Year)	32. Registrar's Si	onature 1	D1. B	101 Sal	ishing V	hd. 3	21801	
	Sta Registra		SFP 0 3	2004 Bener	the desired	Sport	2	*			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 2004 AUG. 30, 4:30 P Angelina Barbierri /Medical Rose 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisbury Nursing and Rehab Center Wicomico Salisbury, Md. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 5. Social Security Number 8. Date of Birth (Month, Day, Year) August 17, 1922 Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 😿 F Director Yrs 137-16-0560 New Jersey Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a Mudical Examinar musibe rediffied at 10d. Inside City Limits Director 1 XYes 2 ☐ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Completed by Funeral 428 Virginia Avenue 21801 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify 3
☑ Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ed bluods 2 Michael Cecere Antonia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or othar tra ODGE. Gerard Barbierri (son) 2429 Lakeland Drive, Pocomoke City, Maryland 21851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) Scringhill Memory Gardens September 2,2004 Salisbury, Maryland 21. Signature of Funeral Service Vice see 22 Name and Address of Facility Holloway FuneralHOme Professional Association 501 Snow Hill Road, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** - PM disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events 001resulting in death) Last Due to (or as a consequence of): burial Physician/Medical the JE FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 atural 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral C 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

BARBIERRI

Box 68760.

Division of Vital Records, P.O.

State Registrar

illiam obins SEP 0 1 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

200 Civic Ave., Salisbury, Md 21804

29d. Date signed (Month, Day, Year)

			1 - For Registrar	State of Mary		artment of ertificate of		70	iene	00700
	Physici	an	1. Decedent's Name (First, Middle, Last)		11			2. Date of Deat Month	h to U	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give s 31825 Mt. Hermon	street and number)	: 1 1		or Location of D	August	4c. County of Wico	Death
#	Funeral Director		5. Social Security Number 6. Security Number 121 – 20 – 8228		yrs. last birthday Yrs.		If Under 24	Hrs. 8. Date of Birth (Month, Day, 03/13/		New York
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicc	omico 10	c. City, Town or L	ocation alisbur	v		-	10d. Inside City Limits 1 ☐ Yes 2 💆 No
	with the	i Director	10e. Street and Number 31825 Mt. Herm	on Rd		10f. Zip Code	804	10	og. Citizen of What	at Country?
396	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-1 show aumalic avent, it a Macinal Examinational Descripted at	by Funeral	<u> </u>	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:	in U.S. 13.		Hispanic Origin? ban, Mexican, Pi	(Specify Yes or No- uerto Rican, etc.)	14. Race -	American Indian, White, etc. white
Maryland 21215-0036	within 72 horiene. then "nature to Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	edent's Usual Occu e kind of work done DO NOT use retire	during most of ed)	working	16b. Kind of Busin	•
yland ?	d tal	To Be C	17. Father's Name (First, Middle, Last) Richard S. Bell				18. Mother's France		ibelli	
	1 and Health em 27 ther tr	8	19a. Informant's Name/Relationship (Ty.  Marjorie M. Be  20a. Method of Disposition	ll/wife	31 Ob. Place of Disp	B25 Mt.	Hermon			,MD 21804
altimore,	permit. Pages Department of I Important: If its sny injury or o once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)  Signature of Funeral Service License		arsons	matory or other pla Cemete: 2. Name and Addr	ry 9	/2/2004		ury, MD sional Assoc
m —	88 5 8	1	23a. Pert1. Enter the disease, or compli	1	F-3P	501 Sno	w Hill	Rd.,Sali	sbury,	MD 21804 Approximate
8760,	death certificate be executed  By American and a strength of or use as the burial-transit	dicai Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to unmediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	Due to (or as a co	nsequence of):	-2.ex	on D	129029		Interval Between Onset and Death // wonth
.O. Box 6	death certif e attending od for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnand □ Other (specify) _	у		23d. Date o Month	-
rds, P.	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions con	tributing to death but no	t resulting in the t	inderlying cause gi	ven in Part I.	23e. Did toba		te to the cause of death?  Probably 4 □Unknown
Vital Records,		Completed						24a. Was an autopsy perform	prior	e autopsy findings available r to completion of cause of th? Yes 2 \(\sumbole\) No
	Physician: Th rthis certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatie	nt 3 DOA Ot	har	Death (Check only one Home 5 resider		Specific
Division of	r Attending Physier death. ier death. irector: After this i by the funeral di	atlon: T	27. Mann Death  1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Inju		28d. Describe how		<i>эрв</i> спу)
DIVID	0 = 0 =	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S				City or Town,	State)	r Rural Route Number,
	To the Hospitat within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of my ner: On the basis of exa- and manner stated.	knowledge, deat mination and/or in	h occurred at the ti vestigation, in my	me, date and pla opinion, death of	ace, and due to the cau courred at the time, dat	use(s) and manne te and place, and	or as stated. due to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier			29c. Licen:	se number	29	d. Date signed (M	fonth, Dey, Year)
- 1	1		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,		50743	,	8/30/	2004
) (	X		Robert Brandon	210.0. 1	acr Pa	rogerdr	0. 5	ialistary	MD	21501
186	Sta Registr		31. Date filed (Month, Day, Year) AUG 3 1 20	32. Registrar's S	nunature /	spou		(		

		1 - For State Registrar	State	of Marylar		artment of F		nd Mental H	lygiene Reg. No	2001	29789
Physici	an	Decedent's Name (First, Middle,  Management	Last) Cathe		Drawno			2. Date of Month	Death Da EMBER	7 2004	3. Time of Death
/Medic		Margaret  4a. Facility Name (If not institution,			Byrne	4b. City, Town, o	r Location of			County of Death	7:15 p M
Examir	ier	St. Mary's Hos				Leonard				St. Mary	's
Funeral			S. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of	Birth Day, Year)		lace (State or Foreign
Director		020-26-9496	1□M 2ÅF	93	3 Yrs.	Months Days	Hours	Min. (Month, Apri.	L 28,	1911Massa	
pu 🛾		Usual Residence of Decedent  10a, State 10b, County		100 Ci	ty, Town or Lo	postion					Od Incide City Limite
sho ed a	ŏ	100.000,	•	100. 01							0d. Inside City Limits 1 ☐ Yes 2 ☐ No
the A 28a-i	ect	MD St. Ma	iry s		Leonar	10f. Zip Code			10a Ci	tizen of Whal Cour	
with 3a or	Funeral Director	22680 Cedar La	no Coumt			· ·	20650			ited Stat	
death ma 2	nera	11. Marital Status	12. Was Dec	cedent Ever in U	I.S. 13.			in? (Specify Yes or Puerto Rican, etc.)		14. Race - Americ	can Indian,
affer of		1 Never Married 2 Marrie	d 1 ☐ Yes	2 (XNo				Puerto Rican, etc.)		Black, White,	
eurs ours	d by	3 XWidowed 4 ☐ Divorced	If Yes, G Year or I	Dates:		1□Yes 2XINo	Specify:			Specify: Whi	rte
72 h	Completed	15. Decedent's (Specify only highest		)	(Give	tent's Usual Occup kind of work done	during most o	of working	16b. K	(ind of Business/In	dustry
then within	d E	Elementary/Secondary (0-12)	College 1	(1-4or 5+)		DO NOT use retired	d)		0-	II	
Hygie other ent,		17. Father's Name (First, Middle, La	ast)		поше	maker	18. Mother	s Name (First, Mid		Wn Home	
d be antal	To Be	Joseph Brown	,					trude Ga		, , , , , , , , , , , , , , , , , , , ,	
shoul nd Mari	F	19a. Informant's Name/Relationship	o (Type, Print)		19b. Mailir	ng Address (Street		or Rural Route Nu		or Town, State, Zip	Code)
alth a		Joyce Byrne Sa	avage (D.	AUGHTER)	) 4419	5 Jessic	a Lane	Leonard	cown,	Maryland	20650
S 1 a		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3		20b. F	Place of Diene	estion (Nama of		Date . 10,2004		ocation - City or To	
Page Page ment ant: fi		`4 □Donation 5 □Other (Spe		Br	insfiel	ld-Echols	Crema	tory	Cha	arlotte H	all, MD
portitionicy, Maily Maillo Z 1 Z 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or Itema 23a or 28a-f show spirity or other traumetic event, the Medical Examinar must be nutilised at once.		21. Signature of Funeral Service Lin	censee //	MALL	22	. Name and Addre	ss of Facility	Brinsfie	eld Fu	ineral Ho	me, P.A.
# # # # # # # # # # # # # # # # # # #		May Ke	230,	VUIII	122	955 но11	vwood	Rd. Leona	ardtov		and 20650
		23a. Part1. Inter third ease, or o shock, in heart to lure. List of	one cause on	caused the deat each line.	th. Do not ent	er the mode of dyin	ig, such as ca	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cc	isdic	278	procure	Try	arres	sh		Chiset and Death
/Medical Examiner		, , , , , , , , , , , , , , , , , , ,		(or as a conseq		turne		MI			
	P.	Sequentially list conditions,	D	COS SOL		accu	e	IVII			
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
O, exection and and and and and and and and and an	Exa	resulting in death) Last	Due to	(or as a conseq	quence of):						
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dicai		d. =								
artifica ing pl	Med	IF FEMALE:								200	//
ath ce	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 ☐ Feta	ıl death 3 □	Ectopic pregnancy	,			23d. Date of delive Month	ry Day Year
the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Preg 9□Unkr	nant at time of d nown	leath 5∟	Other (specify)			-	World	104
that the ed by detac		Part II. Other significant condition	s contributing to (	death but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. D	d tobacco i	use contribute to th	e cause of death?
d be	d by							11	⊒Yes 2	□No 3□Prob	ably 4 Unknown
w req	Completed							24a. W	as an	24b Were auto	nsy findings available
vicien: The lav certificate has rector, page 2:	E C					***		au	itopsy irformed?	death?	osy findings available inpletion of cause of
en: ] tificat tor, p	a	25. Was case referred to medical					26 Place o	1 ☐ Ye		1 Tes	2   No
yaici is cer direc	68	examiner? 1 □ Yes 2 X No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	00	ing Home 5 ☐ R		6 ☐Other (Specifi	v)
ng Phya ter this	T:uc	27. Manner of Death	28a. Date		28b. Time of Injury	28c. Injun Worl	y at	28d. Describ			,
ath.	atic	1 Natural 5 Pending 2 Accident Investiga	tion	, , , , , , , , ,	,,		Yes 2 □ No	)			
or Attender de irecten de n by ti	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determina	288. Plac	e of Injury - At ho ding, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location City or	n (Street an Town, State	nd Number or Rura.	Route Number,
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detected to use as the burial-transit		One Confidence (No. 1972)	Dhart is a								
Hosp 24 hol Fune rely fi	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	caminer: On the b	ie best of my kno basis of examina nner stated.	owledge, death ition and/or inv	occurred at the time time of the street of the control of the cont	ne, date and ; pinion, death	place, and due to the occurred at the time	ne cause(s) e, date and	) and manner as st d place, and due to	ated. the cause(s)
o the	Med	29b. Signature and title of certifier	anu mar	mor stated.		29c. License	a number		29d. Dat	te signed (Month, I	Day, Year)
- s + ō		) TRI	ah			D	1706	-6		7.8.0	
a Ar		30. Name and address of person wh	no completed au	ise of death (Item	n 23a) (Type. I		, 100			( )	
7		AVANI D. SHAH	POBX40		ARDTOWN	,	50				
Sta		31. Date filed (Month, Day, Year)	32.1	Registrar's Signa	ature A	Last o					
Sta Registr				-		halls	JU				

MAKGAKET CATHERINE BIKNE

			1 - For State of Maryla	ind / Depa		lealth and l	Mental Hygi	ene	29790
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medi		Stella Kaisell Basdavanos				Month Septemb	er 5, 200	4 1:30 p M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
			8902 Linton Street			er Sprin	g	Montgo	
	Funeral		1 DM 2 DE	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 2	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		Usuel Residence of Decedent	113.			Sept. Z	, 1917 Wa	shington, DC
	land ow			City, Town or Lo	cation				10d. Inside City Limits
	Man Hed	to	Maryland Montgomery	Silver S	Snring				1 X Yes 2 □ No
	h the	Director	10e. Street and Number	722101	10f. Zip Code	7.1	10	g. Citizen of What C	ountry?
	th wit		8902 Linton Street			20901		U.S.A.	
	dear dear	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Was Decedent of H	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No-	14. Race - Am	
98	or it	y.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	1	1□Yes 2\ No		o r nouri, oto.,	Black, Whi	
8	hours	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:					V	Thite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show ha Madical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup kind of work done	pation during most of wor. d)	king	6b. Kind of Business	/Industry
12	withi ene. than	Ę.	Elementary/Secondary (0-12) College (1-4or 5+)	Teach		۵)		Oakview E	lomontary
0	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or flems 23a or 28a-f show event. The Medical Examiner must be routified at		17. Father's Name (First, Middle, Last)	Teaci	ici	18. Mother's Nam	ne (First, Middle, Ma		rementary
lan	lid be lental ked c	To Be	James Kaisell			Kiki St	avropoulo	S	
Maryland	shou and N a mar	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street			City or Town, State, .	Zip Code)
	alth a		Steve L. Basdavanos - Son	8902	Linton S	Street, S	ilver Spr	ing, MD 2	0901
ore	of He fiten		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other pla	ce)	Date 20	c. Location - City or	Town, State
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		'4 □Donation 5 □ Other (Specify)		n Cremato		/2004	Alexandria	, Virginia
alt	permit. Departimport Import any inj		21. Signature of Funeral Service Licensee					neral Home	
_	₹0 E # 8		Claudette Book Lanin				***	sville, M	20781
Н			23a. Part1. Enter the disease, or complications that caused the def shock, or heart failure. List only one cause on each line.	n. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition resulting in death)	o (cer	right				Onset and Death
Н	/Medical Examiner		Due to (or as a conse	iquence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):					
	od d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ć	te be executed ysician and se burial-transit	Exa	resulting in death) Last  Due to (or as a conse	iquence of):					
8760,	ate be executed hysician and the burial-transit	icai							
9	rtifica ng ph s as th	Med	IF FEMALE:						
Вох	death certifica e attending plo od for use as t	an/I	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy	,		23d. Date of del	,
Ö.	the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	death 5□	Other (specify)			Month	Day Year
P.0.	that the de ed by the detached	P	Part II. Other significent conditions contributing to death but not re	sulting in the un	deriving cause giv	en in Part I	23e Did toba	co use contribute to	the cause of death?
Records,	Se C 9	d by	Dementica		, ,		1 ☐ Yes	A.	obably 4 □Unknown
00	w require been signal	Completed					24a. Was an		topsy findings available
Re	he lav e has age 2 :	m d				****	autopsy	d? prior to death?	completion of cause of
ta	an: T lificat lor, pa	Be Co	25. Was case referred to medical			26 Place of Door	1 ☐ Yes & ☐ h (Check only one)	∛No 1 □ Yes	2 🗷 No
<u>=</u>	Physician: r this certific ral director,	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA Oth	or		e 6 Dother (Spec	rifu)
0	ng Ph ter th neral		27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injur		28d. Describe how		,
<u>i</u>	Attending or death. ector: After by the fune	atic	2 Accident investigation	,,		Yes 2 □ No			
Division of Vital	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	nome, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	oital c urs al urs al brel D								
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medicai	29a. Certifier (Check only one) (Check one) (Check o	lowledge, death lation and/or invi	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	within To th compl	Me	29b. Signature and title of certifier		29c. License	e number	29d	Date signed (Month	n, Day, Year)
				an	Do	23528	5	stember	7 7000
	CR(5)		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, F	Print) & APK	na Hen	Qui, ma	J. Levi Congo	1,500 1
			2309 Shorefreed hel	well	ecition.	ms ?	70607		
	Sta Registr		31. Date filed (Month, Day, Year)  2. Registrar's Sign	nature Local	(L)				
	31011		DEL A L FOR						

			1 - For State Registrar	State o	f Marylan		artment of H		nd Mental Hy	giene	2001.	29791
	<b>.</b>		1. Decedent's Name (First, Middle, La	ist)					2. Date of De	aath		3. Time of Death
	Physici /Medic		Donietta Bickle	у					Sep by	n her	2 700	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Examin		4a. Facility Name (If not institution, given		*		4b. City, Town, or	Location of [	Death	4c	. County of Dea	ath
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	Funeral Director			Sex 1 □ M 2 🖾 F	7. Age (In yrs. i 89	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, Da	th ay, Year)	9. Bi	rthplace (State or Foreign ountry)
			Usual Residence of Decedent						sept.	O, I	914 Ita	ту
viano	wow.		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
e Ma	s-fs	cto	Maryland Prince	George's	Coll	ege Pa	ırk					1 ∑Yes 2 ☐ No
ŧ.	or 26	Director	10e. Street and Number	1			10f. Zip Code				izen of What C	ountry?
ath v	8 23a	ra	4709 Fordham Roa	,			20740			U.S		
ler de	Hem	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dece	edent Ever in U. rces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin n, Mexican, P	n? (Specify Yes or No Puerto Rican, etc.)	)-	14. Race - Am Black, Whi	
urs af	al', or	þ	3 MWidowed 4 □ Divorced	If Yes, Giv Year or D	e ates:		1□Yes 2∏ No	Specify:			Specify:	White
2-0000 72 hours af	ical E	Completed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	lent's Usual Occupa	ation	Acceptate a	16b. K	ind of Business	/Industry
igi (	. Man ".	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work done of OO NOT use retired,	iuring most oi ')	r working			
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T Olyon	and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show aumalic event, the Medical Examinar must be notified at	ို	19a. Informant's Name/Relationship	Type Print)		19h Mailir	n Address (Street		or Rural Route Numb		Tour State	Zin Codel
Mar d 2 sh	Ith an 27 is r trau		James Bickley -						t, Alexand			
, <u>s</u>	f Hea itam othe		20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date		ocation - City or	
Page	nt: if iry or		1 ☐ Burial 2 【Cremation 3 [ `4 ☐ Donation 5 ☐ Other (Speci		State				09/04/04	Ale:	kandria	, Virginia
Dallillor Bermit, Pages	Department of Health and Menta important: If Itam 27 is marked any injury or other traumatic evone.		21. Signature of Furieral Service Lice	nsee /		22	. Name and Addres	s of Facility	Gasch's E	uner	al Home	P.A.
<b>n</b> 8	2 5 5 8		Tolletty	Vag					Avenue, H	yatt	sville,	MD 20781
			23a. Part V. Enter the disease, or con shock, or heart failure. List only	plications that c	aused the death ach line.	. Do not ent	er the mode of dying	g, such as car	rdiac or respiratory a	rrest,		Approximate Interval Between
	rysician		Immediate Cause (Final disease or condition	1/	Septice	ma.						Onset and Death
	Medical xaminer		resulting in death)	Due to	or as a consequ	ience of):						
		r G	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a consequ	ience of):						
uted	ansit	Examiner	cause. Enter Undertying Cause (Disease or injury) that initiated events			,						
ou, be executed	en an rial-tr	Еха	resulting in death) Last	Due to (	or as a consequ	ience of):						
ate	syr he	dical		d								
ō ∯	ing pl		IF FEMALE:									
death cer		hysiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregnal irth 2 Fetal	death 3	Ectopic pregnancy				23d. Date of del Month	livery Day Year
કુ	0.0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregn 9☐ Unkno	ant at time of de own	eatn 5∟	Other (specify)					,
The law requires that the	igned by the atte be detached for	۵.	Part II. Other significant conditions	contributing to de	eath but not resu	ilting in the ur	iderlying cause give	n in Part I.	23e. Did t	obacco u	ise contribute to	the cause of death?
	in sign	ed by							10	Yes 2	<b>X</b> No 3□Pr	obably 4 Unknown
acords, law requires (	s been si 2 should l	mpleted							24a. Was		24b. Were au	utopsy findings available
		Com			<del></del>					rmed? 2 LNo	prior to death?	completion of cause of
VIICIAN: T	certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of	Death (Check only o		1 10.00	20110
Phyeir	this co	º,	1 ☐ Yes 2 🗗 No			ER/Outpatien	t 3☐ DOA Othe	r: 4 ☐ Nursir	ng Home 5 Resid	dence (	3 □Other (Spe	cify)
Jing F	after death. Director: After this certifica 3 in by the funeral director, f	lon	27. Manner of Death  1 Natural 5 □ Pending		h, Day Year)	28b. Time of Injury	28c. Injury Work	?	28d. Describe	now injur	y occurred	
VISIOII Attending	death ctor: y the	llcat	2 Accident investigatio 3 Suicide 6 Could not b	e oga Placa	of Injury - At ho	me farm stre	M 1 □ Y	′es 2 □ No	28f Location (4	Street an	d Number of Pi	ural Route Number,
	after Dire	Certification;	4 Homicide determined	buildir	ng, etc. (Specify	)	sot, ractory, office		City or Tov	vn, State	)	irai noute rainiber,
pepita	within 24 hours after death.  To the Funaral Director; A completely filled in by the fu		29a. Certifier 1 Certifying Pl	nysician: To the	best of my know	vledge, death	occurred at the time	e, date and p	lace, and due to the	cause(s)	and manner as	stated.
he Ho	in 24 he Fu pletel	edical	(Check only 2 Medical Examone)	niner: On the ba and mann	asis of examinat	ion and/or inv	estigation, in my op	inion, death o	occurred at the time,	date and	place, and due	to the cause(s)
Tot	To t	Σ	29b. Signature and title of certifier	0			29c. License				e signed (Monti	
			Muchael 12	raid,	(LU)		10.7	4628	7	4	14/00	(
e	20		30. Name and address of person who	. 1 -	e of death (Item	23a) (Type, I	ere Ave	107	Coll.	egi	Park	NG) 20740
	Sta Registr	-	SEP 0 7 200	4 See	egistrar's Signat	dos.	W					

			For State	State of Ma	ryland					and M	lental Hy	giene			00700	
			Registrar			Cei	tificate	e of l	Death			Reg. No.	UUU		49196	
	Physici	an	Decedent's Name (First, Middle, Last)	_							2. Date of Dea Month	Day			3. Time of Death	
	/Medic	al	Laura Almeda				41-00	<b>-</b>			Septem				1:00 P M	<u>-</u>
3	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City,	lown, or	Location of	of Death		4c.	County of D	eath		
_			Frederick Memo  5. Social Security Number 6. Se			al ast birthday)	Fre If Under		ick   IfUnder:	24 Hrs	9 Date of Birt		rede			
П	Funeral Director			M 2036	98	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day	y, Year)	9.		ace (State or Foreign try)	н
			Usual Residence of Decedent		90				-		Aug. 29	191	J6   M	ary	land	_
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation							10	Od. Inside City Limits	š
	a-fs	ctol	Maryland Freder	ick	Mon	rovia									1 ☐ Yes 2 No	)
	ले के or 28	Directo	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What	Coun	try?	
	23e	rail	11942 Fingerboard	Road				21	770			Un:	ited S	tat	es	
	er dez	Funerai	11. Marital Status	<ol><li>Was Decedent E Armed Forces?</li></ol>		S. 13. \	Was Decedif Yes, spec	ent of H	ispanic Ori in, Mexican	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - A Black, V			
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	0		1 ☐ Yes 2		Specify:				Specify:			
8	72 hours after death with the Maryland natural", or ttems 23e or 28a-f show acal Examination in the multiped at			Year or Dates:		16a Danas	tanka Harra	10	- 41			151 16			ite	
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12	within lane. than	шc	Elementary/Secondary (0-12) 7	College (1-4or 5-	+)			nema	•				Own Ho	<b></b>		
b	e filed y al Hygis other I	d)	17. Father's Name (First, Middle, Last)				1101	uema		r's Name	(First, Middle,			me		
lan	lid be lental ked o	To B	Charles L. Riggs						Emma	Δ1m	eda Bak	۵r				
Maryland 21215-0036	2 should be n and Mental is marked raumatic ev		19a. Informant's Name/Relationship (T)	ypa, Print)		19b. Mailin	g Address	(Street a			l Route Numbe		r Town, Stat	e, Zip	Code)	
	D = 1 = 0	ı,	Dolores B. Thomps	on/Daughte	er	11942	. Fine	erb	oard	Road	Monro	via.	Marv	1an	d_21770	
Baltimore,	permit. Pages 1 an Department of Heali Important: if item 2 eny injury or other once.		20a. Method of Disposition 1	Companyal from State	20b. P!	ace of Dispo	sition (Nam	ne of			ate		cation - City			
Ë	Pages nent of I ant: If its ury or o		`4 □Donation 5 □Other (Specify)		Prov	idenc	e Metl	h.Ce	meter	v9/8	/2004	Kem	ntown.	Me	rvland	
ä	Departi Departi Import eny inj once.	U	21. Signature of Funeral Service Licens	see	,	01	Name and	d Addres	s of Facilit	rth	P. A. F	uner	al Ho	m o		
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each lin	the death e.	. Do not ent	er the mode	of dyin	g, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between	
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Ľ	EXGINITE:		Sequentially list conditions,	b												
	led sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	t consequ	ierioe orj.								i		
	xecu and	xar		c. Due to (or as a	consequ	ence of):								+		
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687	tificate ig phys as the	Physician/Medical		0.										+		_
Вох	eath certif attending for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of	deliver	<b>v</b>	
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 3 4 ☐ Pregnant at			Ectopic pre Other (spe						Month		Day Year	
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o,	tw requires that the sbeen signed by the should be detached	by P	Part II. Other significant conditions co	ntributing to death bu	it not r <i>e</i> su	tting in the ur	nderlying ca	use give	en in Part I.		23e. Did to	bacco u	se contribute	e to the	e cause of death?	
of Vital Records,	aquire en sig	ed	Diabetes me	Hitus							1 🗆 Y	'es 2	X(No 3□	Proba	ibly 4 □Unknown	J
900	s b	ompieted	Hupertension	2.							24a. Was		24b. Were	autop	sy findings available	,
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ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical						26. Place	of Death	Check on o					
Ţ.	S S	70 1	examiner? 1 ☐ Yes 2♥ No	Hospital: 1 Inpatier	nt 2 🗆 E	R/Outpatien	t 3 DO	A Othe	9r: 4 □ Nu	rsing Hor	ne 5 Resid	ence (	3 □Other (S	pecity,	)	
			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day		28b. Time of Injury	28	Bc. Injury Work	at	2	8d. Describe h	ow injur	y occurred			
sio	Attanding ir death. ector; After by the fune	cati	2 ☐ Accident investigation	_			М	1 🗆 ,	Yes 2 🗆 i	No						
Division	for Attandate death Director;	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hor . (Specify	m <i>e</i> , farm, stro )	eet, factory,	, office		2	28f. Location (S City or Tow	treet an n, State	d Number or )	Rural	Route Number,	
	ospital or Attan hours after deat uneral Director; iy filled in by the	0														
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	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and manner sta	100.		29c.	License	number			9d Dat	e signed (Mo	onth D	lav Veari	
À	F 3 F 8		hal SI	001 11								q	11.10	1.	ay, / 5a./	
			30. Name and address of person who co			232) (Type	Print'	1	2164	3	A .	- (	1710	4		
			Si 1 1 1 1	MA 65		The comme	3 8	Th.	100-	o T	w 4	٠. ١	. 0	mn	21702	
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				te of Maryland / I				lental Hygi	ene	
			1 - State Ragistrar WCHD/SH 9/13/( 1. Decedent's Name (First, Middle, Last)	04 perDr.	Cen	tificate of D	veatn	2. Date of Death	J. No.	3. Time of Death
	Physici /Medic		Ethel	Marlene		Baker		Month Septembe	r 9, 2004	2:15 A M
	Examin		4a. Facility Name (If not institution, give street a 1025 Hamilton Blvd.	und number)		4b. City, Town, or I			4c. County of Dea	
			5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday)	Hagersto	If Under 24 Hrs.	8. Date of Birth	Washing	
	Funeral Director		214-34-0317 1 M 2	67	Yrs.	Months Days	Hours Min.	(Month, Day, ) Nov. 19,	1936 Man	rthplace (State or Foreign country) Cyland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	vn or Loc	ation				10d. Inside City Limits
	Many I sho	to	MD Washington	Hag	erst	own				1. Yes 2 □ No
	th the or 28g	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What C	ountry?
	ath wi	ral	559 Liberty St.			21740			U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	1 Never Married 2 Married 1 □	is Decedent Ever in U.S. ned Forces? ] Yes 2X No es, Give ar or Dates:		as Decedent of His Yes, specify Cuban □ Yes 2፟ No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
8	2 hour stural	led t	15. Decedent's Education	16a	. Decede	ent's Usual Occupat	ion	16	Bb. Kind of Business	
21215-0036	nithin 72 e. han "na	Completed	(Specify only highest grade comp	llege (1-4or 5+)		ind of work done du O NOT use retired)	iring most of worki	ng		
7	iled w Tygier ther th		1 Z  17. Father's Name (First, Middle, Last)	Mai	nage		19 Mother's Name	(First, Middle, Ma	Food Serv	ice
Maryland	ld be f ental f ked o	To Be	Keller E. Buhrman					M. Bond	iden Sumame)	
ary	shou and M s mar umati	-	19a. Informant's Name/Relationship (Type, Pri	nt) 19t	b. Mailing	Address (Street an	nd Number or Rura	I Route Number, (	City or Town, State,	Zip Code)
	and 2 salth a n 27 l		Wayne E. Baker, Sr./H		59 L:	iberty St	. Hagers		21740	
Baltimore,	Pages 1 ient of He nt: If iter ry or oth		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Remova  4 ☐ Donation 5 ☐ Other (Specify)			ition (Name of atory or other place) Cemetery			c. Location - City of	
Balti	permit. Departmitmoporta Importa any inju		21. Signature of Funeral Service Licensee	1	22.	Name and Address	of Facility Res	st Haven	Funeral (	Chapel
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do						Approximate
Н	Physician		Immediate Cause (Final disease or condition	se on each line.	000	-	mcen			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	- Ca	111000		-	2 MONTAS
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	± தி		IF FEMALE: 23c. If v	es, outcome of pregnancy	-				22d Date of de	Diagram .
P.O. Box	0 0	by Physician/M	in the past 12 months?	]Live birth 2 □ Fetal death ]Pregnant at time of death ]Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
Ś	requires that the wen signed by th hould be detache		Part II. Other significant conditions contributing	ng to death but not resulting i	in the und	derlying cause given	in Part I.			the cause of death?
Š	v requi	eted						1/2/Ves		robably 4 Unknown
Division of Vital Record	The la ate has page 2	Completed						24a. Was an autopsy performe	d2 prior to death?	utopsy findings available completion of cause of
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	:		Other	26. Place of Death			Daughter's
ō	y Phys er this eral di	n: To	27. Manner of Death 28a	Date of Injury 28b.	Time of	3☐ DOA 28c. Injury a Work?	4   Nursing Hon	ne Residence 28d. Describe how	e 6 ☑Other (Spe injury occurred	Daughter's
Ö	Attending or death. ector: After by the fune	atio	1 Alatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		s 2 🗆 No			
Sivis	or Atter after de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e	Place of Injury - At home, fa building, etc. (Specify)	arm, stree	et, factory, office	2	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	Hospital 24 hours a Funeral I tely filled		29a. Certifier (Check only Check only 2 Medical Examiner: Or	To the best of my knowledge	e, death o	occurred at the time,	, date and place, a	and due to the caus	se(s) and manner as	s stated.
	To the h within 24 To the f complete	Medical	one) an 29b. Signature and title pf certifier (	d manner stated.		29c. License r			Date signed (Mont	
	F & F 8					MI) N	1./1.4	3	29/10	104
	A		30. Name lind address of person who complete	d cause of death-((tem 23a)	(Type, P	rint)	MOHI		77/10	10 M 21/40
الح			Hind Hamda	m, (M) @	113	o op	HL	CT. H	agerston	n, moder 140
	Sta Registr		31! Date filed (Month Pay, Year) 2004	32. 9 egistrar's Signature	Signa	ches		/	9	-

	1	For Stete Registrar	State of M		Depa		lealth and	d Mental Hyg		nni.	29794
		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	th Da	y Year	3. Time of Death
Physician /Medical Examine	1	Maudie Sue Ba Ba. Facility Name (If not institution, giv				4b. City, Town, o	r Location of De	Aug.	2	7 , 200 County of Dea	4 3:46 g
		4 Saint Andre	ews Cross	sover			erna P	ark		Anne	Arundel
Funeral Director		430-56-7354	ex 7. Ag □M 2 <b>⊠</b> F	ge (In yrs. last bi	Yrs.	If Under 1 Year Months Days	If Under 24 H		Year)	9. Bi	rthplace (State or Forei ountry) AR
A A	- 1-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Lo	cation					10d. Inside City Limit
or obain with the Marylan lems 23e or 28a-f show cr must be indiffed at		MD Anne A	rundel			Severna	Park		0- 04		1 ☐ Yes 2 反 N
death with the Maryland ms 23e or 28a-f show rmust be routified at	2	4 Saint Andrews C					21146		ug. Cit	izen of What C	JSA
rat', or ite	n by rune	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates:	)		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🔀 No		(Specify Yes or No- erto Rican, etc.)		14. Race - Am Black, Whi Specify:	
vgiene.  vgi	hierer	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	fucation ide completed) College (1-4or		. Deced (Give life. I	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of w f)	vorking	16b. K	ind of Business	/Industry
Hygiene.  Other than  ent, I'm	5		5		nysi	cal Educa	ation Te	eacher	E	ducatio	on
yes I and 2 should be hed write for an of the all hand Mental Hygiene. If I them 27 is marked other than "nature or other traumatic svent, it a Medical To Be Commission.	מ	17. Father's Name (First, Middle, Last, James A. Dean						ame (First, Middle, I e Elma Pe		,	
alth and h		19a. Informant's Name/Relationship ( Grover M. Barha		191				Rural Route Number	-		Zip Code) ark, MD 211
rages I and tent of Health ut: If Item 27 ry or other tr		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Other (Specif		cemete	ary, cren	sition (Name of natory or other place  Mem. Gard	e) Se	Date ep. 4, 2004		cation - City or cahontas	
permit, Page Department o Important: If any injury or once.		21. Signature of Fune at Service Licen		- Turido.	Ba	Name and Address	Sons,	P.A. Seven Hwy, Seven	na	Park Fi	neral Home
Special of the price of the pri	LYa	shock of heart failure. List only Immediae Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence	of):	pneu	uania				Interval Between Onset and Death
attending p for use as I		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 21□ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death		Ectopic pregnancy Other (specify)			2	23d. Date of de Month	livery Day Year
been signed by the should be detached	n n	Part II. Other significant conditions of Cultural	ontributing to death b	out not resulting i	in the ur	derlying cause give	en in Part I.		acco u		o the cause of death?
ate has								24a. Was a autops perforr 1 \( \text{Yes} \) 2	٧		utopsy findings availab completion of cause of
r this certificate ral director, pag	2	25. Was case referred to medical examiner?	Hospital:			Othe	10	eath (Check only on			
fler this neral di		1 ☐ Yes 2 No  27. Manner of Death  1	28a. Date of Inju (Month, Da		utpatien Time of Injury	28c. Injury Work	at (?	Home 5 X eside 28d. Describe ho			cify)
To the Hospitel or Attending P within 24 hours alter death to the Funeral Directors filler completely filled in by the funeral Medical Certification.	Celulicae	2 Accident investigation 3 Suicide 6 Could not be determined		ury - At home, fa c. (Specify)	arm, stre	M 1 1	Yes 2 □ No	28f. Location (St. City or Town			ural Route Number,
e nospire 124 hours e Funera letely fille	alcai	29a. Certifier 112 Certifying Ph (Check on) 2 Medical Exer	ysicien: To the best niner: On the basis o and manner st	f examination ar	e, death	occurred at the timestigation, in my op	e, date and pla- pinion, death oc	ce, and due to the ca curred at the time, da	use(s) ite and	and manner as place, and due	s stated. e to the cause(s)
To th comp		29b. Signature and title of certifier		-		29c. License	number	29	d. Date	e signed (Mont	h, Day, Year)
	-		completed cause of a	leath (Item 22a)	/Tues	Dō	5707	8	8	-30-0	4
		30. Name and address of person who ADITY A C. HOPK	10. MD 61	ORIGO	el		e. 23   f	tonapoli	S <sub>1</sub> 7	ND.Z	140/
State Registrar		31. Date filed (Month, Day, Year)	32. Figistr	ar's Signature	)	and I			-		

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland	-		of Health of Death			iene	4 29795
	Physici	ın	Decedent's Name (First, Middle     JEWELL	e, Last) K			BUSIC			Date of Death Month		3. Time of Death 4:45 P M
	/Medic Examin		4a. Fecility Name (If not institution		)			wn, or Location		GUS1 Z	4c. County of (	
			5639 MT HOLLY					EW MARI				IESTER
T	Funeral Director		5. Social Security Number  213-26-0280  Usuel Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2  F	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Y	ays Hours	Min.	Date of Birth (Month, Day, eb. 16		Birthplace (State or Foreign Country)  Virginia
	yland Now		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Ba-fat	ctor	Maryland Dorche	ster	Eas	t New	Market					1 Tes 2 No
	with th	Directo	10e. Street and Number				10f. Zip Co				og. Citizen of Wha	
36	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28e-f show the Medical Exerciter most be notified at	by Funeral	5639 Mt. Holly  11. Marital Status  1 Never Married 2 Marital Status  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1  Yes 2	?		216 Was Deceden if Yes, specify 1 □ Yes 2 ☑	t of Hispanic O Cuban, Mexica	an, Puerto Rica	Yes or No-	Black, \	ates American Indian, White, etc. white
5-0036	n 72 hours afte "natural", or l		15. Deceden	nt's Education		16a. Dece	dent's Usual C	Occupation done during mo	et of working	1	16b. Kind of Busin	ness/Industry
21215	ithin 7	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)		DO NOT use i		ist of working			
N	filed with Hygien Hygien Sther the		12. Father's Name (First, Middle,	l ast)			clerk	18 Mott	ner's Name (Fi	rst. Middle. N	departm	ent stores
auc	e d la	To Be	Presley Dean	2001)					y Ann			
Maryland		F	19a. Informant's Name/Relations	thip (Type, Print)		19b. Mailir	ng Address (S		<del>-</del>		City or Town, Sta	ate, Zip Code)
	and 2 saith a n 27 is		Jim Busic/ son				The second second			9	MD 21613	
Baltimore,	Pages 1 ar nent of Hea int: If item iry or othe		20a, Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S		, a	emetery, crer	esition (Name matory or othe e Crem	or place)	Date		20c. Location - Cit	5370
Balti	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	Licensee Long	die	22	2. Name and A	Address of Faci	lity John	M. Ta	ylor Fun	eral Home, Inc is, MD 21401
,160,	Physician and /Medical Examiner sthe parisition and street	cal Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	t only one cause on each I	ine.  Wor s a consequence of the	n A uence of):	d L		s cardiac or re	spiratory arre	ist.	Approximate Interval Between Onset and Death  3 Moss
P.O. Box 687	The law requires that the death certificate ate has been signed by the attending physogge 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Alo. 9 □ Unknown	23c. If yes, outcome  1  Live birth  4  Pregnant a	2 Fetal	I death 3[	⊒Ectopic pregi □ Other (speci				23d. Date o Month	
	w requires that been signed b should be deta	by	Part II. Other significant conditi	ons contributing to death	but not resi	ulting in the u	nderlying caus	se given in Parl	11.			ute to the cause of death?  Probably 4 Unknown
Vital Records,		e Completed	25. Was case referred to medica	al.				26 Pla	ce of Death (C	24a. Was ar autopsy perform 1 Yes 2	prio dea	re autopsy findings available or to completion of cause of th? Yes 2 2 No
	A is D	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatier	nt 3 DOA	Other		*7	nce 6 Other (	(Specify)
Division of	Attending r death. ector: After by the fune	Certification:	27. Manner of Death 1 ØHatural 5 ☐ Pendir 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place of In	ay Year)	28b. Time o Injury	М	. Injury at Work? 1 ☐ Yes 2 ☐	□No		w injury occurred  reet and Number of State)	or Rural Route Number,
۵	To the Hospital or within 24 hours after To the Funeral Direction completely filled in It		29a. Certifier 17 Gertifyii	ng Physician: To the best	t of my kno	wledge, deat	h occurred at	the time, date a	and place, and	due to the ca	use(s) and manne	er as stated.
	the Ho lin 24 the Fu	Medical	one)	Examiner: On the basis of and manner s		tion and/or in						
)	To To con	2	29b. Signature and little of certific	Telens			296.	26 3	38-8	- 1	August	31, 200 4
			30. Name and address of person	I Fradde	w 1	n 23a) (Type. M	Print)	ellins	Heer	lock n	August ncl 21	643
	Sta Regist		31. Date filed (Month, Day, Year, SEP 0	1 2004 32. His	trar's Signa	ture A	book					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 2004 **Physician** Sept. 8:00 Рм Worthington Campbell, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Williamsport Washington Homewood at Williamsport If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** M 2 F Director 081-24-9414 07/14/1922 unk Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event. It is Medical Evant and must be notified at 1 ☐ Yes 2X No Director Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16505 Virginia Avenue 21795 US by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Ie marked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Episcopal Priest Religion 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Louise Hooper Worthington Campbell, Sr. Lyes 1 and 2 sho 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fiduciary Trust Co., 175 Federal St., Boston, MA 02110 Rosalyn Sovie / Per. Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Duxbury Crematory 09/14/2004 Duxbury, MA 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mouths /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 🗌 Yes 32 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

de ath. after de ath To the Hosp within 24 ho To the Fune completely fi

24.8

State

Medical

4 | Homicide

29b. Signature and title of certifier

29a. Certifier

Registrar

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

nanner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Hagosta

Vorthan

		1 - State Registrar				Cei	rtificate of	Death		giene Reg. No	0001	0070
Physic		Decedent's Name (First, Mi		) Linda Kay	e Coffey	<b>V</b>			2. Date of Do Month September	Da	•	3. Time of Death
/Medi Exami		4a. Fecility Name (If not institu				/	4b. City, Town, o	Location of Dea			. County of Death	
Funeral Director	este-	St. Mary's Nur 5. Social Security Number 216-70-8618	6. Se		7. Age (In yrs.	last birthday) 47 Yrs.	Leonardt If Under 1 Year Months Days			rth a <i>y, Year)</i>		lace (State or Foreign offry)
2		Usual Residence of Decedent 10a. State 10b. Cou			100 0	b. Town and						
re more and man with the many and natural', or Items 23a or 28a-f show dical Examiner must be notified at	Director	Maryland Sai	nt Mar	cys	100. Ci	ty, Town or Lo	lcsville					0d. Inside City Limi 1 ☐ Yes 2 1 1
a or 2	Ö	10e. Street and Number					10f. Zip Code			10g. Cit	izen of What Coun	itry?
hall Hygiene.  No other than "natural", or Items 23a or 28a-f show event, If a Medical Examinar must be notified at	by Funeral	27548 Gold Lane  11. Marital Status  1 Never Married 2 N	1arried	12. Was Deced Armed For 1  Yes If Yes, Give	ces? 2 [X] No e		20659 Was Decedent of H f Yes, specify Cuba	ispanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No orto Rican, etc.)	0-	USA  14. Race - Americ Black, White,  Specify: White	etc.
n "natural" Vedical Ex	Completed b	3 ☐ Widowed 4 💆 Divorce  15. Decec  (Specify only high	ient's Edu hest grad	le completed)		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of w	orking	16b. K	ind of Business/Inc	
Il Hygiene. other than "	Com	Elementary/Secondary (0-12	2)	College (1-	-4or 5+)		Homemaker				Own Home	
ital Hygird other	Be	17. Father's Name (First, Midd	lle, Last)					18. Mother's Na	ame (First, Middle	, Maiden	Sumame)	
f Health and Mental item 27 is marked o other traumatic eve	-L	Joseph Franc				10h Mailia	Addross /Ctrost		te Crouch	0'1	- T Ot- 4- T-	0.41
aalth an n 27 is r ier traur		Charles William			ushand		Box 43 Mecl					Code)
ment of Health ant: If item 27 ury or other tr		20a. Method of Disposition  1 □ Burial 2 ☒ Crematic  4 □ Donation 5 □ Other	on 3 □F	Removal from S	20b. I	Place of Dispo cemetery, cren	sition (Name of natory or other plac	e) Se	Date eptember	20c. Lo	ocation - City or To	
Department of Important: If i any njury or ones.		21. Signature of Funeral Servi			ner	22 Ma	n Cremator Name and Address attingley-G O. Box 270	s of Facility	2004 ineral Home	. P.A	andria, Vir	zinia
		23a. Partil. Enter the disease shock, or heart failure.	or compl	ications that ca	used the deal						0000	Approximate Interval Between
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	aDue to (c	or as e consec	quence of):	mal	osa	,		1	Onset and Death
xaminer		Saquentially list conditions,		b	No	lon	Cana	90				4)
and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	【.	c	or as a coñsec							
physician and the burial-transit	dical E	. Joseph J. G.		d.	or as a consec	quence or):						
the attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2		th 2 ☐ Feta int at time of c	aldeath 3□	Ectopic pregnancy Other (specify)				23d. Date of deliver Month	ry Day Year
d by	by Pf	Part II. Other significant cond	itions cor	ntributing to dea	ath but not res	ulting in the ur	deskie e ee ee	o in Part I	23e Did t	obacco u	se contribute to the	e cause of death?
an signed uld be dei							idenying cause give			Yes 2	No 3 ☐ Proba	ably 4 □Unknow
ite has been sign bage 2 should be							loerlying cause give		1 🗆 Yas	an	24b. Were autop	sy findings availab
ite has been sign	Be Completed	25. Was case referred to med examiner?		dosnital:				26. Place of De	1 1 24a. Was autor	an osy ormed? 2 10 No	24b. Were autop prior to com death?	sy findings availab
h, After this certificate has been sign funeral director, page 2 should be	To Be Completed	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pen	F	28a. Date of		ER/Outpatien 28b. Time of Injury	3□ DOA Cthe	26. Place of De	24a. Was autoperfo	an osy ormed? 2 10 No one dence	24b. Were autop prior to com death? 1  Yes	ssy findings availab apletion of cause of 2 No
fler death. Director: After this certificate has been sign in by the funeral director, page 2 should be	To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Nanner of Death  2 Accident  3 Suicide  6 Cou	ding	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury	3□ DOA Cthe	26. Place of De	24a. Was autop performent of the control of the con	an osy ormed? 2 20 No one dence 6 how injury	24b. Were autop prior to com death?  1 Yes :  6 Other (Specify, y occurred	osy findings availab apletion of cause of 2  No
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death. ctor: After this certificate has been sign / the funeral director, page 2 should be	To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pen 2 Accident 3 Suicide 6 Cou 4 Homicide dete	ding stigation ild not be armined ying Physial Examin	28a. Date of (Month)  28a. Place of building	Injury  Injury  Definjury - At hing, etc. (Specification)  Dest of my knows of examina	28b. Time of Injury	28c. Injury M 1 1 2000 Det, factory, office	26. Place of De  17. 4 ☑ Nursing at ??  26. Yes 2 ☐ No e, date and place inion, death occ	24a. Was autop performed at the time,	an psy promed? 2 120No pne dence 6 thow injury. Stete, cause(s) date and	24b. Were autop prior to condeath?  1 Yes:  GOOther (Specify, y occurred)	Route Number,
within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	edical Certification: To Be Completed	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of cert	ding stigation ld not be simined ld not be simined ld not be simined ld not be simined ld not be simined ld not be simined ld not be simined ld not be simined ld not be simined ld not be simined ld not be similed ld not be simil	28a. Date of (Month)  28e. Place of building sician: To the base and manns	Injury Day Year) of Injury : At high get. (Special Special Spe	28b. Time of Injury  ome, farm, stre yy)  owledge, death attion and/or inv	28c. Injury Work  M 1 20  28c. Injury Work  1 20  28c. Injury Work  1 20  28c. License	26. Place of De  17. 4 Nursing at ??  28. Versing at ?  29. Version e, date and place inion, death occurrence of the Community  OE 4	24a. Was autop performed at the time.	an psy promed? 2 120No pne dence 6 thow injury. Stete, cause(s) date and	24b. Were autop prior to condeath?  1 Yes:  GOOther (Specify, y occurred)  do Number or Rural and manner as staplace, and due to	esy findings available pletion of cause of 2 No  Route Number,  ated. the cause(s)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** September 4,2004 1:35pm Ruth Pauline Emma Cady /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Bradford Oaks Nursing Home Clinton 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1□M 2√XF 79 Yrs Washington DC 577-18-5051 June 17 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County 28a-f show other traumetic event, It we Madical Exercimer must be notified at 1 Yes 2 No Maryland Prince George's Fort Washington Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ö 10949 Riverview Road 20744 United States or Items 23e death Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If Item 27 le marked other then "neturel" or injury or other traumetic event. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: Specify: 3 → Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Reseach Tech Investigation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Friedrich G. Lindner Emma R. Lindner 19a. Informant's Name/Relationship (Type, Print) John Cady (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6707 Burch Hill Road, Brandywine, Maryland 20613 20a. Method of Disposition
1 ⚠ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Cedar Hill Cemetery Sept 8, 2004 Suitland, Maryland \*4 □Donation 5 □Other (Specify)

21. Signature of Fig. 1 and Service License 22. Name and Address of Facility Lee Funeral Home, Inc. al Service Licenae 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 🗌 Yes 2 200 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 🗆 No certificate 1 ☐ Yes 1 🗌 Yes Hospitel or Attending Physician: Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 2 XNo Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Tes 2 ER/Outpatient 3 DOA this: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number completed cause of death (Item 23a) (Type, Print)
Fman M.D. 12070 Old Line Centre #207 Waldorf, Maryland 20602 30. Name and address of person who completed cause Louis V. Kaufman M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 0 8 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Golden Candelora September 2, 7:45 p<sup>M</sup> 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crescent Cities Center Riverdale Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye April 22, 9. Birthplace (State or Foreign Country)
Washington, DC **Funeral** Year, 577-28-7686 82 1922 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28e-f show rthen "natural", or Items 23a or 28e-f shov the Medical Evanth et must Let notified at 1 X Yes 2 No Director Maryland Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4302 38th Street 20772 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No δ Specify: Specify: White 3 ☐ Widowed 4 X Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Government 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Office Assistant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permii. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event 9DR9. Arlious Humphries Ada Gaylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard M. Candelora - Son 4302 38th Street, Brentwood, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 09/04/04 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. audette 4739 Baltimore Ave., Hyattsville, MD 20781 da 23a. Part1. Enter the disease, or complications that ceused the such. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, loading to animodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dua to (or as a consequence of) burial-transit or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? then sclentic vancular Discos. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2/5 No 1 ☐ Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo this nours after death.

nere! Director: After this tilled in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1/5 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel L Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D48213 September 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam Ashai, M.D. 4410 74th Avenue, Landover Hills, Maryland 20784 . Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 7 2004 Registrar

3ER	T CARTE	R	For State Registrar			Maryland		artmen rtificate			and M		Reg. No.		2081	_م
	Physicia	_	1. Decedent's Name Robert I		ter, Sr.							2. Date of De. Month SEPT .	Dav	2004 <sup>Year</sup>	3. Time of 3:48	Death PM
	/Medic Examin	_	4a. Facility Name (If DOCTORS	not institution, COMMU	give street and numb NITY HOSP	oer) LTAL			Town, or VHAM	Location o	of Death		4c. Co	ounty of Death		
	Funeral Director		5. Social Security Nu 251-46-352 Usual Residence of I	22	6. Sex 7 1 X M 2 ☐ F	Age (In yrs. last 69	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Aug., 17	, 1935	9. Birth Cou Green	place (State or ntry) Tille, SC	Foreign
	/land			10b. County		10c. City, T	Town or Lo	ocation							10d. Inside Cit	y Limits
	e Man	ctor	MD F	rince G	orge's	Lanham	ı								1 <b>X</b> ]Yes	2 🗌 No
	th with the 23s or 28 sates or 28	Funeral Director	10e. Street and Num 8908 Walker		<i>r</i> e			10f. Zip	Code	20706			10g. Citize	n of What Cou A	ntry?	
980	72 hours after death with the Maryland "natural", or items 23a or 28e-f show patcal Exaculturer and be notified at	þ	11. Marital Status 1  Never Marrie 3  Widowed 4		Armed Ford	□ No	1	Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Race · Ameri Black, White pecify: Blac	etc.	
21215-0036	permit. Pages 1 end 2 should be filed within 72 ho Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other treumetic event. It a Medical once.	Completed			s Education grade completed)  College (1-4	lor 5+\	(Give life.	dent's Usua kind of woi DO NOT us ing En	rk done d e retired,	luring most )	t of worki	ing		of Business/Ir	1	
Maryland 2	12 should be filed within h and Mental Hygiene. 7 is marked other than " ireumetic event, the Mark	To Be C	17. Father's Name (F Furman Ba		ast)							e (First, Middle, e Moore	Maiden Su	ımame)		
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Balt	permit. Pag Department Important: any injury o		21. Signate of Fun	eral vervice L	icense Mari	une	) 22	Name and Tyrope	d Addres J. Y Kenne	s of Facility Young I	funera reet,	al Servic NW Wast	es ington	, DC 20	011	
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8760,	eate be executed by sician and the burial-transit	dical Examiner	Sequentially list con- tary, leading to the cause. Enter Under Cause (Disease or in that initiated events resulting in death) La		c	r as a consequen										
O. Box 6	requires that the death certificate be executed een signed by the ettending physician and hould be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 9 Unknown	nonths?		h 2 ☐ Fetal de nt at time of death	ath 3[	Ectopic pro					230	f. Date of deliv Month	*	ear
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Division of	ling Ph I. After th Tuneral	Certification: To	1 Yes 2 Nanner of Death 1 Natural 2 Accident 3 Suicide	5 Pending investig	28a. Date of (Month, ot be	Injury 28 Day Year) 28	Outpatier  Bb. Time o Injury  BLOD  a. farm. str	рм <sup>21</sup>	Bc. Injury Work	at ?	No C	ne 5 Residence R	vehicle	ccurred LINVOVA	ed in m	
D.	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t		4 Homicide  29a. Certifier (Check only	determin	building	est of my knowle	ect	b occurred :	at the tim	e, date and	d place a	City or Tow 1900 Wind	m, State)	Charel A	d. George	
	To the H within 24 To the Fu	Medical	one) 29b. Signature and t		xaminer: On the bas and manne	is of examination r stated.	and/or in		. License				29d. Date s	igned (Month,	Day, Year)	
•	a R (in)		30. Name and addre	ss of person v	which, Monday			,						T. 3, 2	4004	
	Sta	te	Pumela E. 31. Date filed (Month	SOUTHO Day, Year)	//, M.D	sistente Ciametere			et, l	Balti	more	, Maryl	and 2	1201		
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m		rd Crissman, Jr Plea 1_ State	State	of Marylan	u / Dep	artmen	t of H	eaim	and iv	iental Hy	giene				
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Physic	an			-						Month		13.	Ž004	3. Time o	P M
/Medi		Paul Richar  4a. Facility Name (If not institution				4b. City.	Town, or	Location of	of Death	Берсен			of Death	0.33	
Exami	ler	Calvert Memori	al Hospit	al		Pr	ince	Fred	lerio		C		ert		
Funeral Director		5. Social Security Number  220–11–0854  Usual Residence of Decedent	6. Sex 1 M 2 ☐ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 2/12/1	a <i>y, Year)</i>		9. Birthp Coun	lace (State etry) MD	or Foreig
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Modical Existing fruit be rectilised at any Injury or other traumatic event, if a Modical Existing fruit be rectilised at any Dices.	ō	10a, State 10b. Count		10c. City	, Town or L								1	0d. Inside C	ity Limits
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Attending Physician: The law requires that the death certificate be redeath. sctor: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	outcome of pregna birth 2 Fetal gnant at time of de known	death 3	⊒Ectopic pr ⊒ Other (sp					2		te of delive	,	Year
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		30 Name and address of person	n who completed ca	- Toll	l 23a) (TVDA	, Print)	0.	C.M.E			Septe	mbe	r 04,	2004	
	1													21201	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Donald Charles Comlish September 2004 8:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Death Examiner eake Beach Calvert 8077 Windward Key Drive Chesapeake 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□F Months Days Hours Min. Director 68 12/30/1935 CT 047-26-0665 Usual Residence of Decedent 10c. City, Town or Location Show 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 Styles 2 □ No Director 28e-f Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 8077 Windward Key Drive 20732 death Funeral <u>USA</u> 12. Was Oecedent Ever in U.S. Armed Forces? 1 tgYes 2 □ No If Yes, Give Year or Dates: 1954–57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married ŏ Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: δ 3 Widowed 4 Divorced White "nature!" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) 5+ Airline Industry Attorney f Health and Mental Hygie Item 27 is marked other other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental 2 Charles Comlish Helen Horkheimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 i or other tre 8077 Windward Key Drive, Chesapeake Beach, MD Carol Comlish/ Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury of once. 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 9/7/2004 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond-Wood Funeral Home, P.A. 0 PO Box 430, Dunkirk, Maryland 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NGES **Physician** YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burialattending physician Box 68760 Physician/Medical as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ĺ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4 Pregnant at time of death 5 Other (specify) P.O. the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 0 No 1 ☐ Yes 3 Probably 4 Unknown certificate has been si rector, page 2 should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performeg 2- No 2 □ No 1 Tyes 1 Tes Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 ☐ Other (Specify) (h) funeral 27. May er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) empleted cause of death (Item 23a) (Type, Print) 30. Name and address of perso 10+1 Date filed (Month, Day State 0 Registrar

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	with the	Director	10e. Street and Number 1117 Woodlyn Road			10f. Zip Cod	e 21401			10g. Citizen of W USA	hat Coun	itry?	
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altimore,	Pages 1 ar		20a. Method of Disposition  1  Burial 2  Cremation 3    4  Donation 5  Other (Specify)		cemetery,	Disposition (Name of crematory or other p	olace)	Sept.	1,	20c. Location - 0	•		
Baltil	permit. Pages Department of Important: If it any injury or o		21. Signature of Fureral Service Licens			22. Name and Ad Barranco 495 Gov.	dress of Faci & Sons Ritchi	s, P.A	. Sev	erna Par erna Par	k Fu	neral	Home 6
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisate or injury that initiated events	b. — Due to (or as a	consequence of	):							
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ds, P.	signed be de	by	Part II. Other significant conditions co	ntributing to death but	not resulting in t	he underlying cause	given in Part	I.	23e. Did to	bacco use contri		e cause of de	
Vital Records,	The law ate has b page 2 st	Completed				-			24a. Was a autop perfor 1 Yes	med? pr	ere autorior to consath?	osy findings annietion of car	vailable use of
Vita	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/Outp	atient 3☐ DOA	Othor		(Check only or	ne) Jence 6 □Other	/Canaik	4)	
lon of		ation; To	27. Manner of Death  1 ENatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		ne of 28c. Ir	njury at Work?	28		ow injury occurre		9	
DIVISION	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director; After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, fam (Specify)	n, street, factory, office	се	28	Bf. Location (S City or Tow	treet and Numbe n, State)	r or Rurai	Route Numb	er,
	e Hospitel 124 hours a e Funerel ( letely filled	edical	29a. Certifier 1 Certifying Phy (Check only one)	vsicien: To the best of iner: On the basis of e	examination and/	death occurred at the or investigation, in m	e time, date a ny opinion, de	and place, areath occurred	nd due to the c d at the time, d	cause(s) and man date and place, ar	ner as stand due to	ated. the cause(s)	
	To the Hos within 24 hor To the Fun completely	Med	29b. Signature and title of certifier	/		29c. Lice	ense number		2	29d. Date signed	. 11	Day, Year)	
			30. Name and address of berson who co	ompleted cause of day	Ath (Item 22a) (T	vne Print)	1196	5		8/30/	69		_
			Juseph	Friend	. 1/6	Defeure	· Hw	y M	nng	clis, w	N-:	21401	
	Sta Registr		31. Date filed (Month, Day, Vear)	32. Registrar	's Signature	Shorth			V	,			****

CPM 04-05898 Zane Clayton

bygioign		Registrar			Certificate	e of L	Death			eg. No.	101.	2001
Physician	_	Decedent's Name (First, Middle, L							2. Date of Deal	Day	Year	3. Time of Death
/Medical	-	Zane la. Facility Name (If not institution, go		ayton	4h Cin	Tour or	Location o		Septemb	_	ounty of Death	20:46
Examiner		223 Challedon Dr					ville				Frederic	ck
uneral	5		Sex 7. Age	e (In yrs. last bir	rthday) If Under	r 1 Year	If Under 2	24 Hrs.	8. Date of Birth		9 Rintho	lace (State or Fore
rector		214-17-1364	1 <b>⊠</b> M 2□F 2	23	Yrs. Months	Days	Hours	Min.	lov. 27	,′°1′98	0 Washi	Lington, D
<b>*</b> *	-	Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	n or Location							0d. Inside City Lim
reho india	5 N	Maryland Carroll		Mount								1 Yes 2 1
Le nutified Director	5	10e. Street and Number		Hount	10f. Zip	Code			1	0g. Citizer	n of What Cour	21
38 or		3837 Mount Airy	Drive			2177	1			-	S.A.	
od other than "natural; or items 23a or 28a-f show event, if a Medical Evarable must be notified at Be Completed by Funeral Director		11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Was Deced	dent of Hi	ispanic Orig	gin? (Spec	ify Yes or No-	14.	Race - Americ Black, White,	
variation it		1 Never Married 2 Married	If Yes, Give	No	1 ☐ Yes	**	Specify:	, , , , , , , , , , , , , , , , , , , ,		Sc	oecify: Whit	
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Important: If item 27 is marked other than any injury or other traumatic event, ItaMs once.  To Be Compl		17. Father's Name (First, Middle, Las							(First, Middle, M		,	
To F		Zane Shephard C	layton				Do	rothy	Marie	Lewi	.S	
E ma	7	19a. Informant's Name/Relationship	(Type, Print)	196	o. Mailing Address	(Street a	and Numbe	r or Rural	Route Number	City or To	own, State, Zip	Code)
am 27 ther t	-	Zane S. Clayton  20a. Method of Disposition	- Father		837 Moun		ry Dr	ive,				
or of	1	1X Burial 2 ☐ Cremation 3		cemete	ry, crematory or o	other place					tion - City or To	
njury .	1	<ul> <li>4 □ Donation 5 □ Other (Spec</li> <li>21. Signa ure of Fureral Set the Lice</li> </ul>	- 0	nyatts	stown Me							ı, ma.
any ir		21. Signature of Popular Service Lice	Al. Olina	u N					.A., Ft			00070
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Gay Durr September 4,2004 3:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Cherry Hill Assisted Living Accident Garrett If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Director Yrs. 214-52-1789 91 Sept. 17, 1912 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Garrett 0aklnad Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 257 Durr Road 21550 death v USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ™Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8th Housewife Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyol.
Importent: If item 27 is marked any injury or other? Ith and Mental Hygid 27 is marked other of treumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 01iver Lipscomb Anna Elizabeth M0reland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Elliott/daughter 181 Durr Road, Oakland, Md. 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Lantz Ridge Cemetery | 9/7/2004 Aurora, WV 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Stewart Funeral Home S. Second St., Oakalnd, Md. 21550 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Encephalopathy vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed signed by the attending physician and deelached for use as the burial-transit Due to (or as a consequence of): Records. P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death Day 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by High Blood Pressure 2. No 1 ☐ Yes 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient //tel or Ah.
-ours after death.
-al Director: After h.
- by the funeral dir 1 Tes 2 ER/Outpatient 3 DOA this LIVING 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D15333 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson M.D. 311 N. Fourth St., Oakland, Md. 21550 31. Date tiled (Month, Day, Year) State 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month September 1, Agnes 2004 Marguerite Dalton 7:15 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner St. Mary's 24556 McIntosh Road Hollywood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F Director 578-03-9011 89 March 10,1915 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow ral, or items 23a or 28a-f ahor Examiner must be notified at Director 1 ☐ Yes 2 No MD St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24556 McIntosh Road 20636 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Completed by 3 ₩ Widowed 4 Divorced "natural" It e Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home item 27 is marked other other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be finent of Health and Mental | sut; if item 27 is marked o Frank Carroll Barbara Magdalene Peacock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) 24556 McIntosh Road Hollywood, Maryland 20636 Harry Dalton Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sept. 2,2004 ortant: if i 1 Burial 2 XCremation 3 Removal from State Department o Important: if any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crematory Charlotte Hall, MD 21. Signature A Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List orly one cause on each line. Immediate Cause (Final disease or condition resulting in death) mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physicien and the burial-transit Due to (o Box 68760, use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | 1 Yes 2 No detached 9 Unknown 2 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2. No 1 Yes or Attending Physician: ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 1 Yes 26 No Medicai Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA luneral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel within 24 hours a To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number 29b. Signature an le of certifier 29d. Date signed (Month, Day, Year, 10 ss of person who complet cause of death (Item 23a) (Type, Print) 24035 Three Notch Rd. Hollywood, Maryland 20636 Ratrick Jarboe M.D.

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Morth, Day 1979)

32. Registrar's Signature

			1_ For				/ Depa	artment of H	Health and I	Mental Hygi	ene	ole.	
			* Registrar					tificate of	Deam		g. No.	14 2	9807
	Physic /Medi		1. Decedent's Name (First, Middle, l Jasper Louis Dougla	-						2. Date of Death Month September	Day Year		3. Time of Death 9:48 P. M
	Exami		4a. Facility Name (If not institution, g	ive street and nu	ımber)			4b. City, Town, o	or Location of Deatl	h	4c. County	of Death	
			Southern Maryland H	ospital				Clinto	on		Prince	George'	S
	Funeral		Social Security Number 6.	Sex	_	(In yrs. last		If Under 1 Year Months Days		8. Date of Birth			e (State or Foreign
	Director		213-46-9712	1 M 2 □ F		56 	Yrs.			October 7,		Marylan	
	and		Usual Residence of Decedent  10a. State 10b. County			10c. City, To	own or Lo	cation				10d	. Inside City Limits
	Aaryla I sho	0				-						100	1 ☐ Yes 2 ☐ No
	the t	Director	Maryland Charles  10e. Street and Number			Wald	ori	10f. Zip Code		10	g. Citizen of W	/hat Country	
	aa or		11828 Brooks Manor	Drive				20603		"	USA	mat country	
	death with the Maryland ms 23a or 28e-1 show	Funerai	11. Marital Status	12. Was Dec	edent Ev	ver in U.S.	13. V		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		- American	Indian,
	after or Ite	F	1   Never Married 2 Married	Armed F	2(X) No	)				o Rican, etc.)		k, White, etc	·
	-0036 hours after turel; or ite	d by	3 Widowed 4 Divorced	If Yes, G Year or E	ve Dates:		1	☐ Yes 2⊠ No	Specify:		Specify.	: Black	
	nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylar N of Health and Mental Hygiene. If Item 27 is marked other then "neturet", or Items 23s or 28e-f show or other treumatic event. It a Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education grade completed)	)	16	6a. Deced	lent's Usual Occup kind of work done	pation during most of wor	kina 1	6b. Kind of Bu	siness/Indus	stry
	laryland 21215- 2 should be filed within 72 and Mental Hygjene. Is marked other then "net eumatic event, I.e Madis.	Idm	Elementary/Secondary (0-12)	College (					during most of word)				
	the transfer to the transfer t		11 17. Father's Name (First, Middle, La	et)		C	onstru	ction Work	1	ne (First, Middle, M	Constru		
	and be fortal head of	Be		31/							aiden Surnami	Β)	
	Tylenk d Me mark matik	은	John Jasper Douglas  19a. Informant's Name/Relationship	(Type Print)			9h Mailin	a Address (Street		rie Thomas	City or Town	Ctata Zin Ca	
3	Mand 2 s th an th an treum		Charles Seabright Do		thor	- 1							
	tem tem		20a. Method of Disposition	Jugias/Dic	rener	20b. Place	of Dispos	sition (Name of natory or other pla	orner Road,	Mechanicsv:	LIIE Man		
	Pages ent of ht: If i		1XXBurial 2 □ Cremation 3  '4 □ Donation) 5 □ Other (Spec		State	1 .		natory or other pla norial Gard	Septer	mber 13,			
	Baltimore, Mispersity of permit. Pages 1 and 2 Department of Health improrent: If item 27 is eny injury or other treounce.		21. Signature of Funeral Service Lic					. Name and Addre		+ <u>L</u> (	eonardto	wn Mar	yland
	Depariment of the parameter of the param		Machael	XIII.		1	Ma	ttingley-C	Gardiner Fu	neral Home, 20650	P. O. Bo	ox 270,	
	15-11		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that	caused	he death. D						Ar	oproximate terval Between
	Physician		Immediate Cause (Final disease or condition	h	AD A					cular			nset and Death
	/Medical		resulting in death)	a. Due o	(or as a	consequence		0 000	alvice	cuac	UI SUIC	. PC	
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2	P #	Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury		(ui do a	consequenc	20 OI).						
30	ecute and trans	Cam	Cause (Disease or injury that initiated events resulting in death) Last	c									
ouglas	Vital Records, P.O. Box 68760, sicien: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	cai E		Due to	(or as a	consequenc	e or):						
( )	687 ifficate g physi	dic		d									
,	ontifica ding ph	/Me	IF FEMALE:	23c. If yes, ou	tcome of	pregnancy					2015		
る	Box death cert e attending	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	birth 2	Fetal dea		Ectopic pregnancy Other (specify)	/		Z30. Date Mon	of delivery th Da	y Year
0	P.O.	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn									
	ecords, P.O law requires that the as been signed by th	by Pi	Part II. Other significant conditions	contributing to d	leath but	not resulting	g in the un	derlying cause giv	ren in Part I.	23e. Did toba	cco use contri	bute to the c	ause of death?
8	rds quire an sig uld b	ed b								1 🗆 Yes	2 □ No :	3 🗌 Probabi	y 4 Nnknown
\3	aw re	Completed								24a. Was an	/ 24b. W	ere autopsy	findings available etion of cause of
	The I	mo							<del></del>	autopsy performe	ed7 de	for to compli eath? □Yes 2[	
	ita ian: artifica ctor.	Bec	25. Was c - e referred to medical examiner?						26. Place of Dea	th Check on one		3.00	2110
,	of Vita Physician: this certific ral director,	0	1 Dres 2 No			2 VER/0	Outpatient	3□ DOA Oth	er: 4 Nursing H	ome 5 Residen	ce 6 Othe	r (Specify)	
	Ing P Viter t unera	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	of Injury th, Day	Year) 28b	Time of Injury	28c. Injur Wor	y at k?	28d. Describe how	injury occurre	d	
	Sio	cati	2 Accident investigate 3 Suicide 6 Could not	bo -					Yes 2 □No				
	Division of Vital Records, to a Attending Physician: The law requires that after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification;	4 Homicide determine	d 289. Place	of Injury ing, etc.	y - At home, (Specify)	farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	r or Rural Ro	oute Number,
	pitel curs a erel i		29a. Certifier 1 Certifying	nysician: To the	Anact of	my knowled	lan doath	accurred at the time	no data and class	and due to the cau	(-)		
	Division of Vital Rectant the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Extended)	aminer: On the o	asis of e	xamination a	and/or inv	estigation, in my o	pinion, death occur	red at the time, date	se(s) and man e and place, ar	ner as stated and due to the	d. e cause(s)
_	To the vithin To the somple	Me	29b. Signature and title of geryfigh					29c. Licens	e number	290	I. Date signed	(Month, Day	, Year)
	. , , , ,		· / ///,	$/ \wedge$				D5	8428		9/11	0/4	
	720		30 Name and address of person who	o completed caus	se of dea	th (Item 23a	a) (Type, F			Λ ( · · · ·			0 = =
	()		Robert MEC	Kstall		7503	3 50	urratt.	3 Kd	Clintol	1,110	1 20	735
		ite	31. Date filed (Month, Day, Year)		legistrar'	s Signature	-						
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Marylan		irtment of F tificate of i		nd Mental Hy	giene	101.	2000	
			Decedent's Name (First, Middle	e, Last)					2. Date of De.				
	Physici		EVELYN	Α.		ת	AVIS		Month Controm	Day	Year		
	/Medio Examin		4a. Facility Name (If not institution		imber)		4b. City, Town, or	r Location of [		September 3, 2004 5:10 A			
	C. Adiriii	CI	St. Catherines					tsburg			Frederi	a1-	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		Hrs. 8. Date of Birt	th			
	Director		218-05-2624	1 □ M 2 🗖 F	93	Yrs.	Months Days	Hours	Hrs. 8. Date of Birt (Month, Da AUG . 3 ,			place (State or Foreign htry)	
			Usual Residence of Decedent						AUG. J,	1911	Platy	land	
	ylan		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits	
	Mar Mar	ţo	Maryland Frede	erick	İ	Thurmo	nt					1≰2 Yes 2 □ No	
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cour	ntry?	
	death with the Maryland ms 23a or 28a-f show rrwat be rediffed at	123 Bennett Drive					217	88		Unit	United States		
	deat	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. V	Vas Decedent of H	ispanic Origin	? (Specify Yes or No		. Race - Americ	an Indian,	
36	be filed within 72 hours after death with the Marylan Ital Hygliene. Ind other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	by Fu	Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	If Yes G	2 No ive		Yes, specify Cuba ☐ Yes 2 🛣 No	Specify:	'uerto Hican, etc.)	s	Black, White,		
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	filed Hygi ther ant,		17. Father's Name (First, Middle,	Last)			Install		Name (First, Middle,			acturer	
Maryland	should be nd Mental marked o	To Be	John	М.	Davis	;			lsie		Martin		
ary	w	_	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a		or Rural Route Numbe	er, City or 1			
Š	nd 2 alth a 27 is		Sylvia Weant	/ Niece			Bennett I	277	nurmont, M				
ē,	item 27		20a. Method of Disposition		20b. P	lace of Dispos	sition (Name of patory or other place		Date P1		ation - City or To		
5	e		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State			1	106 10001	TD1.			
altimore,	# 문문를		21. Signature of Funeral Service	· · · · · · · · · · · · · · · · · · ·	PTU		e Cemeter Name and Addres		/06/2004				
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			shock, or eart failure. List	only one cause on	each line.	- 0	IA +	g, ocorras car	-1	-	4	Interval Between Onset and Death	
-	Physician / /Medical	disease or condition resulting in death)  a. Consulting in death)  a. Consulting in death)											
	Examiner			Due to	or as a conseq	uence of):	4	0 1		1	1-	20.	
		6	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									c 20 yr	
	ted nsit	Examiner	Cause (Disease or injury		210-01							20000	
	xecu and al-tra	xar	that initiated events resulting in death) Last	c	(or as a conseq	uence of):	na					12	
9	cate be executed physician and the burial-transit				00	,						0	
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	= D 0		IF FEMALE:	23c. If yes, or	tcome of pregna	nncv							
Вох	death cert e attendin id for use	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	I death 3	Ectopic pregnancy			23	<li>d. Date of delive Month</li>	ry Dav Year	
o.	he dr the ched	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr		eam 5	Other (specify)						
Δ.	The law requires that the tee has been signed by thoage 2 should be detache		Part II. Other significant condition	ons contributing to c	leath but not resi	ulting in the un	deriving cause give	an in Part I	23e Did to	pacco use	contribute to th	e cause of death?	
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ec	has be 2 s	npi							24a. Was autop	sy	prior to con	osy findings available inpletion of cause of	
=	10	S							perfor 1 ☐ Yes	med? 2 <b>2 N</b> o	death?	2 💢 No	
/ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?					26. Place of	Death (Check only or	ne)		1	
of C	Attanding Physicien: r death. ector: After this certifics by the funeral director, I	ဥ	1 ☐ Yes 2 No			ER/Outpatient	3□ DOA Othe	er: 4 Nursir	ng Home 5 ☐ Resid	ence 6	Other (Specify	)	
Ē	Ing P	on:	27. Manner of Death  1 Natural 5 □ Pendir	28a. Date (Mor	of Injury hth, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe h	ow injury o	occurred		
sio	Attandi death. ctor: A y the fu	cati	2 Accident investig	001 00				Yes 2 □ No					
Division of Vital Records,	or Att	Certification:	3 Suicide 6 Could determ	ined 289. Place	of Injury - At ho ing, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and f	Number or Rural	Route Number,	
	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.												
	Hosp 4 hou Fune ely fi	edical	29a. Certifier 1 Certifyir (Check only 2 Medical	g Physician: To the Examiner: On the b	e best of my kno easis of examina	wledge, death tion and/or inv	occurred at the time	ne, date and p	lace, and due to the o occurred at the time, o	ause(s) an	nd manner as sta	ated.	
	To the P within 24 To the F complete	Med		1 1	iner stated.								
	To To	-	29b. Signature and title of dertifle		( ).	11	29c. License	number	725	29d. Date s	signed (Month, L	Jay, Year)	
•				ra	Or.	uoll	my 4	1718	105	7	1.30	04	
	i L		30. Name and address of person									(	
	4.			/ 310 S.			Emmitsbu	rg, Ma	ryland 21	727			
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signa	ture	lon	1.					

D D		For State Registrar	State o	of Maryl			artment of H tificate of I			•	giene Reg. No.?	Ani.	2	nonn
Physicia /Medica		1. Decedent's Name (First, Middle, L Chantel	ast)				Dorsey			2. Date of De Month Septem	Day	3, 20	ar	3. Time of Death
Examine Funeral Director					vrs. last birth		4b. City, Town, or  Upper Mo If Under 1 Year  Months Days	arlb	O <b>YO</b> er 24 Hrs.	8. Date of Birt (Month, Pa st 8, 19	4c. (	ince (	eoro	e (State or Foreign
D	_	Usual Residence of Decedent 10a. State 10b. County  Maryland Prince G	eorges	10c.	City, Town		cation		riage	DC 0,13		rac	10d.	Inside City Limits 1 X Yes 2 No
In yielling Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other than "natural", or itema 23a or 28a-f show matic event, the Madical Examinat must be multipled at	Funeral Directo	10e. Street and Number 1213 Crisfield Dr 11. Marital Status	12. Was Dec	edent Ever i	n U.S.	13. V	10f. Zip Code 2074  Vas Decedent of Hi	spanic (	Origin? (Spe	ecify Yes or No	US	4. Race - A	merican	
2 hours after atural, or ite	ò	Widowed 4 ☐ Divorced  15. Decedent's 8	1 □ Yes If Yes, Gi Year or D	ye ve vates:	16a. D	Эесес	f Yes, specify Cuba I ☐ Yes 21\(\frac{1}{2}\)No Ient's Usual Occupa	Specia	fy:			Black, W Specify: B ad of Busine	lack	
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permit. Pages 1 and 2 Department of Health Important: if Item 27 any njury or other tre	12	Martin Holt/ Fath  20a. Method of Disposition  1 △ Burial 2 □ Cremation 3  `4 □ Donation 5 □ Other (Spec	☐Removal from	State	b. Place of D cemetery,	Dispo cren	Fareham sition (Name of natory or other place Cath Ch	e)		Oate /O4	20c. Loc	Maryla cation - City ntown	or Town,	State
Departition of the post of the		21. Signature of Funeral Service Lice  Compared to the disease, or compared to the disease to the	Has		1323	Ac	Name and Address	ral	Home	P.A. Ac	uasc			
	edical Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any leading to minodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a con	sequence of	ln.	jurile		as cardiac o	i espiratory ar	1031,		Int	proximate erval Between sset and Death
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Jinknown		birth 2   F	etal death		Ectopic pregnancy	·			23	3d. Date of o	delivery Day	y Year
w requires that been signed to should be detailed.	ρλ	Part II. Other significant conditions	contributing to d	eath but not	resulting in t	he ur	nderlying cause give	en in Par	t I.		obacco us	_	to the ca	ause of death?
ician: The iaw certificate has bector, page 2 s	e Completed	25. Was case referred to medical						26 Pla	ce of Death		sy med? 2 \( \subseteq No	24b. Were prior t death 100 Y	o comple ?	findings available etion of cause of
for Attending Physical Control of Street Control of Street Control of Street Control of Street Control of Street Control of Street Control of Street Control of Street Control of Street Control of Street Control of Street	Sertification; To B	examiner?  1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine	28a. Date (Mon Fund 28e. Place	of Injury oth, Jay Year	t home, farm	ne of ury 719	28c. Injury at Work?  AM 1 □ Yes 2 □ No include the factory, office  28f. Location (Sire City or Town,				Jence 6 Dother (Specify) Scene Jown injury occurred with rule will will be still the still will be still		divery	
To the Hospit within 24 hours To the Funera completely fille	Medical C	29a. Certifier (Check only one)  1□ Certifying F 2☒ Medical Exe 29b. Signature and title of certifier	miner: On the D	e best of my pasis of examiner stated.	knowledge, and/	death or inv	occurred at the time restigation, in my op 29c. License O.C.1	numbe	eath occurre	ed at the time, o	date and p 29d. Date	ind manner place, and d signed (Mo tember	ue to the nth, Day,	cause(s) Year)
Stat Registra	-	30. Name and address of person who  The WO DE M  31. Date filed (Month, Day, Year)  SEP 0 9	completed cau	se de death (		уре, І	Print) 111 Per	nn S	treet	, Balti				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			T = State of Maryla		rtificate of L		Re	g. N2. 0 0 4	29810
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Deborah S. Dorr				August 2	29°, 2004 <sup>ear</sup>	3. Time of Death 4:55 AM M
	Examin		4a. Facility Name (If not institution, give street and number) Millennium at South River		4b. City, Town, or Edgewat		4c. County of Deat		
	Funeral Director		579-14-0641 1 <sup>1</sup> M 2 R F 83	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, Feb. 12,	9. Birt 1921 Wash	hplace (State or Foreign untry) ington, D.C.
	the Maryland 28a-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Arundel  10e. Street and Number	Riva					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a or	ral Dir	12 Shore Walk Road		10f. Zip Code 2114	0		g. Citizen of What Co USA	untry?
036	tiled within 72 hours after death with the Maryland Hygiene tther than "natural", or Itams 23a or 28a-f show thit, the Medical Examil act mattle medified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give ↑ Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2전No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh:	e, etc.
21215-0036	s filed within 72 h I Hygiene. other then "natu ant, the Medicu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	_	kind of work done during most of working DO NOT use retired)			6b. Kind of Business/ Federal Go	·
	d ta b	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		,	
Maryland	2 should and Men la marke aumatic	Ţ.	Leo E. Streitberger  19a. Informant's Name/Relationship (Type, Print)	19b. Mailir		Deborah D nd Number or Rura		OWN) City or Town, State, 2	Zip Code)
	1 and Health am 27 ther to		Jack Dorr/Son  20a. Method of Disposition 20b.		ore Walk isition (Name of natory or other place			21140 oc. Location - City or	Town, State
Baltimore,	00-		1 Bullat 2 Clattation 3 Brantovat notif State	alas Cr	ematorv	08–30	–04 Ed	lgewater, N	Maryland
Rai	permit. Pag Department Important: I any Injury o		21. Signature of Funda Septem Licenses	$\sum_{i=1}^{22}$	2. Name and Address 973 Solone	<sup>s of Facility</sup> Geo ons Islan	rge P. K	Kalas Funer	ral Home , Md. 21037
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the dec shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)	ath. Do not ent	er the mode of dying	, such as cardiac o			Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	quence of):	ficiend	y			
68760,	rificate be executed og physician and as the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
.О. Вох 68	death cer e attendir d for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fermant at time of 9 □ Unknown	tal death 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
٦.	The law requires that the te has been signed by tho bage 2 should be detache	b	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause give	n in Part I.		acco use contribute to	the cause of death?
al Records,	(0 -	Completed					24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of 2 No
i Vital	hysician: nis certifica I director, I	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes}  \text{2No} \) No  Hospital:  1 \( \text{Inpatient}  2 \)	☐ ER/Outpatien	at 3 DOA Othe	26. Place of Death  4XXVursing Hon		nce 6 Other (Spec	sify)
Division of	Attanding Physician: It death. sctor: After this certific by the funeral director,	Certification;	27. Manner of Death  1 X Natural 2 Accident 3 Suicide 6 Could not be	28b. Time of Injury	Work M 1 □ Y	? 'es 2 🗆 No	8d. Describe hov		
Σ	Hospital or Attand 24 hours after death Funaral Director: tely filled in by the	Certif	4 Homicide determined 28e. Place of Injury - Atl	nome, rarm, str hify)	eet, factory, office	2	81. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Month	
			30. Name and address of he son who completed cause of death (Ite	em 23a) (Type,	Print)	7023		8.300	4
	Sta	ato.	ADITY ACHOPRA MD. LOOK 31. Date filed (Month, Day, Year) 32. Registrar's Sign	2 idgel	y Ave. 5	He-231 A	nnapol	8.300 15,140.2	1401
	Regist		AUG 3 1 2004	· K	Small ,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar 9-14-04, dan, st. marys co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sept 4, <sup>Day</sup>004 DeCenzo 4:55 P.MM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Life Springs Elder Care Camp Springs Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**√X** 2□ F 81 577 24 6343 1923 Ohio Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Marvland Prince George's 1 ☐ Yes 2XXXVo Director Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5208 Lansing Drive 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give XX Year or Dates: À 1 ☐ Yes 2☐ No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Aid School Board 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carmine Ingagliato Candita Gambone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Joseph L. DeCenzo (Husband) 5208 Lansing Drive, Temple Hills, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 2004 20c. Location - City or Town, State 20a. Method of Disposition Sept 16. 1 X Purial 2 Cremation 3 Removal from State Arlington National Cemetery Arlington, Virginia `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Maryland 20735 2 Approximate

Pnysician /Medical **Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

þ

Box 68760.

P.O.

Division of Vital Records.

Hospitel or Attending Physicien:

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burial-1 the the use as s been signed be should be deta within 24 hours after death.

To the Funerel Director: Af

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	tification; To Be Completed by Physician/Medica

IF FEMALE

23b. Was decedent pregnant

1 ☐ Yes 2 🗓 📉 o

9 Unknown

in the past 12 months?

Mayor. NU	and moo257	Alexandira	Ferry	Road,	Clinton,
	mplications that caused the dea y one cause on each line.	ath. Do not enter the mode of dying,			
Immediate Cause (Final disease or condition resulting in death)	a. ATHER	SCLEROTIC Sequence of):	HEA	52 D	SEAGE
Sequentially list conditions. if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	живпсь от).			
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	equence of):			

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ No Nown

Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9□ Unknown

24a. Was an performed? 1 Yes 2 V No

24b. Were autopsy findings available prior to completion of cause of death? 1 🗆 Yes 2□ No

Interval Between Onset and Death

Year

25. Was case referred to medical examiner? 1 Yes XXNo 27. Manner of Death

5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

3 DOA 28c. Injury at Work?

Other: 4 XX ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

26. Place of Death Check onl one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number City or Town, State)

(Check only

29a. Certifie

Medical

2 Accident

4 Thomicide

3 Suicide

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and itle of ourtifier

29c. License number D30583 29d. Date signed (Month, Day, Year) Sept 7, 2004

30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print)

John Van Dam, M.D. 3508 Old Silver Hill Rd, Suitland, Maryland 20746 31. Date filed (Month, Day, Year)

Registra

SEP 0 8 2004



	1 - State Registrar	State of Man	•	rtificate			•	giene Reg. No.	nni.	29812
m	Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month	ath Day	Year	3. Time of Death
Physician /Medical	Betty	Ellis					Sept.	3, 2	004	5:10 A.
Examiner	4a. Facility Name (If not institution, give	e street and number)		4b. City, To	wn, or Location	on of Death			County of Deeth	1
	6785 Edward Ave	•		S	alisbu	ry		Wicomico		
Funeral	Social Security Number     6. Security Number		n yrs. last birthday)	If Under 1		der 24 Hrs.	8. Date of Birti (Month, Day	h ( Vaar)	9. Birth	place (State or Fore
Director	543-18-5074  Usual Residence of Decedent	□M 2XIF 78	Yrs.	Months	Days Hou		9-12-19	925 Nebraska		
M #	10a. State 10b. County	10	c. City, Town or Lo	cation						10d. Inside City Lim
if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic avent, the Healtcal Examinar must be notified at To Be Completed by Funeral Director	Md. Wicomio	20	Salisbur							1 □ Yes 2 🕅
Le notified Director	10e. Street and Number		Salisbul	10f. Zip Co	ode	·		10a Citi	zen of What Co	intry?
0	6705 71 1 1									
or tems 23.	6785 Edward Ave		rin II S 12 1		1804	Origin? (Spe	ody Voc or No	US	SA 14. Race - Amer	ican Indian
the land	1 Never Mamed 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2♣ No	1110.3.	f Yes, specify	Cuban, Mexi	ican, Puerto F	cify Yes or No- lican, etc.)		Black, White	
by	3 Widowed 4 Divorced	If Yes, Give		1 ☐ Yes 2 ☐	XNo Spec	ity:			Specify: LTL	ite
a Pe	15. Decedent's Ed		16a Door	ient's Usual (	Nan matina			405 40		
t, the Medical E Completed	(Specify only highest gra	ide completed)	(Give	kind of work of NOT use it	done during n	nost of workin	g	16D. Kii	nd of Business/li	ndustry
a E	Elementary/Secondary (0-12)	College (1-4or 5+)			retired)			C.	chool	
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raumatic avant, tra Maranata avant, tra Maranata avant, tra Maranata avant, tra Maranata avant a	17. Father's Name (First, Middle, Last)						(First, Middle,			
10 af	Ray White				R	uth Co	lclesse	er V	√hite	
Eng.	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailir	g Address (S	treet and Nut	mber or Rural	Route Numbe	r, City or	Town, State, Zi	p Code)
1	Paula K. Baumann	, Daughter	6858	Zion	Church	Rd.,	Salisbu	ry,	Md. 218	304
other tra	20a. Method of Disposition		20b. Place of Dispo	sition (Name	of or place)	D	ate	20c. Lo	cation - City or T	own, State
y or	1 ☐ Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Cremator	y of D	elmarv	a 9-4-	04	De:	lmar, DI	Ε.
eny injury or once.	21. Signature of Funeral Service Licen			. Name and A					,	
eny in		1		hort F			Inc.			
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9		antributing to doub but a	nt regulation in the country	alaukiina nam		a l	OD- Dida-			he cause of death?
Phys	TENTE I CHIME SIGNIFICANT CONDITIONS OF	onthoday to doubt but in	or resenting in the di	identyling caus	o disantut ca	14.1.	200. DIG (0	_	/	
<b>2 2</b>	Part II. Other significant conditions co									oabiy 4 🗆 Unkno
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b b	Fact II. Other significant conditions of						24a. Was a	ın	24b. Were auto	ppsy findings availal
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rector, page 2 should be d	25. Was case referred to medical examiner?	Hospital:	2[] <b>5</b> B/Outpation	2 2 DOA	Othor		24a. Was a autops perfori	in Sy med? 2 X No	prior to co death? 1 🗆 Yes	mpletion of cause of
al director, page 2 should be d	25. Was case referred to medical examinar?	1 L Inpatient	2 ☐ ER/Outpatien		Other: 4 🗆	Nursing Hom	24a. Was a autops perform 1 Yes Check on your e	in sy med? 2 X No	prior to co death? 1  Yes	mpletion of cause of
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cation; To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury  At home, farm, stre	28c.	Other: 4   Injury at Work? 1   Yes 2	Nursing Hom 28 □No	24a. Was a sutops perfori	med? 2 No ence 6	prior to co death? 1  Yes	mpletion of cause 2□ No
in by the funeral director, page 2 should be director.	25. Was case referred to medical examiner? 1   Yes   2   No   27. Manner of Death 1   Natural   5   Pending   2   Accident   Investigation   3   Suicide   6   Could not be determined   29a. Certifier   Certifying Physics   Certifying Physic	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (S  ysician: To the best of manner. On the basis of each	28b. Time of Injury  At home, farm, stre pecify)  y knowledge, death	M eet, factory, of	Other: 4   Injury at Work? 1   Yes 2	Nursing Hom 28	24a. Was a autops perform 1 Yes / Check on your e Standard Describe holds. Location (Si City or Town	nned? 22 No ence 6 pw injury	prior to co death?  1 Yes  Other (Special Coccurred)	impletion of cause of 2 No 2 No (y)  al Route Number,
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			1 - For State Registrar		Maryla	nd / Depa		of He	alth an	d Mental H		e	ne.	29812	
	Physic	ian	Decedent's Name (First, Middle,	Last)						2. Date of D		ay	Year	3. Time of Death	
	/Medi			Susanne Len		wards				Septemb			1041	3:00 A M	
	Exami	ner	4a. Facility Name (If not institution, g	give street and number	er)		4b. City, To	wn, or Lo	cation of D	eath	4	4c. County of Deeth			
			19290 Pristine Way				Dray				S	Saint M	arys		
Н	Funeral			5. Sex 7 1 ☐ M 2 🛱 F	Age (In yrs	. last birthday) 46 Yrs.	If Under 1 Months		Under 24 I Hours N	Hrs. 8. Date of B	irth Day, Yea	r)	9. Birtho	olece (State or Foreign	
	Director		560-55-6175 Usual Residence of Decedent			40 115.				Decembe	r 15,			higan	
	yland yland		10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits	
	Mar	to	Maryland Saint Ma	arve			Desarridan							1 ☐ Yes 2 🖄 No	
	h the	<u>e</u>	10e. Street and Number	11 / 3			Drayden 10f. Zip Co	de			10g. C	itizen of WI	nat Cour	ntry?	
	th wit	aiD	19290 Pristine Way					20630	)						
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or itams 23e or 28e-f show event, the Madical Exerting must be notified at	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	nt Ever in L	J.S. 13.	Vas Deceden			(Specify Yes or Nuerto Rican, etc.)	0-	USA 14. Race - American Indian,			
9	or ft	F	1 Never Married 2 Married	1   1   Yes 2		1	⊺Yes, speciny 1 🗌 Yes 2 🖸			ierto Rican, etc.)			White,		
Maryland 21215-0036	ral',	d by	3 Widowed 4 Divorced	Year or Dates	Year or Dates:			S ON4	ipecity:			Specify:	Whi	te	
7	72 h	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Deced	lent's Usual C	ccupatio	n na most of	working	16b.	Kind of Bus	iness/Inc	dustry	
7	Mithir Iban	E G	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. I	kind of work o	etired)	· · · · · · · · · · · · · · · · · · ·	······································					
N	filed w Hygien Sther th	ပိ	17. Father's Name (First, Middle, La	3			Artist							tractor	
ğ		Be	_	51/				18	. Mother's f	Name (First, Middle	e, Maide	n Sumame,	)		
Ž	2 should by and Menta Is marked aumatic ev	၉	Donald Lee Smith  19a. Informant's Name/Relationship	Con Dian					Carol	yn Joyce 0:	lson				
<u>B</u>										Rural Route Numi			tate, Zip	Code)	
	1 and Health em 27 thar tr		Dennis Lee Edwards /	Husband	20h	19290 Place of Dispos	Pristin	e Way	Drayd	en, Marylan		_			
altimore,	0 0		1 ⊠ Burial 2 ☐ Cremation 3		e St.	George	natory or other	place)	Se	Date ptember	20c. L	ocation - C	ity or To	wn, State	
	permit. Peg Depertment Important: I eny injury o		*4 Donetion 5 Other (Spec			Cemeter	У			,2004	Vall	ey Lee,	Mary	yland	
g	permit. Peg Depertment Important: I eny injury o		21. Signature of Funeral Service Lic	2 deni	0 0	Ma	. Name and A ttingley	-Gard	liner F	uneral Home	e, P.	Α.			
2-			23a. Pert1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	ed the dear	th. Do not ente	O. Box 2	70 Le	onardt	own, Maryla	and 2	0650		Approximate	
	Centificate be executed from the principle of the principle as the burial-transit principle as the burial-transit principle as the principle of the principle o	ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c. Due to (or a d.	s e consec	quence of):	DENO	CAR	LINON	nA - Unh	now	N tim	6,50	Onset and Death	
<u>.</u>	death e atter d for u	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	Il death 3 🗌	Ectopic pregn. Other (specif)					23d. Date of Month		y Day Year	
v.	The law requires that the te has been signed by th oage 2 should be detached.	by Pi	Part II. Other significant conditions	contributing to death	but not res	ulting in the un	derlying cause	given in	Part I.	23e. Did t	obacco	use contribu	ite to the	cause of death?	
corus,	equire									10	Yes 2	ENO 31	_ Probal	bly 4 Unknown	
ັນ	law r as be 2 sh	Completed								24a. Was	an	24b. Wei	re autoos	sy findings available	
		Ю									rmed?	prio	r to com th?	ptetion of cause of	
חום	inan: ortific ctor,	Be	25. Was case referred to medicat examiner?					26	Place of D	1 ☐ Yes eath (Check only of		1 1 1	Yes 2	! ∐ No	
>	Physician: The lav this certificate has ral director, page 2 :	2	1 ☐ Yes 2 ☑ No	Hospital: 1  Inpat	ient 2	ER/Outpatient	3 DOA	Other		Home 5 Aesi		6 □Othor (	Canada)		
5	ding Pl h. After ti funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Di	ury av Year)	28b. Time of Injury		njury at Work?		28d. Describe			эреспу)		
2	ath.	atic	2 Accident investigation	on	.,	Inquiry		Yes	2 🗆 No						
	To the Hospitel or Attending R within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of In	iury - At ho	ome, farm, stre	et, factory, offi	сө		28f. Location (: City or Tox	Street an	d Number o	or Rural I	Route Number,	
	pitel ors a mel [		200 Cartina all Cartina												
:	24 ho 24 ho Fun etely	Medical	29a. Certifier  (Check only one)  Certifying P  2 Medical Exa	hysician: To the best miner: On the basis of and manner s	of my kno of examina	wledge, death tion and/or inve	occurred at the estigation, in m	e time, da ny opinior	ate and place n, death occ	ce, and due to the curred at the time,	cause(s) date and	and manne place, and	r as stat	led. he cause(s)	
	vithin Fo th	Me	29b. Signature and title of certifier					ense nun				e signed (A			
	2		& Esmal						296				,		
4	SNC I	-	30. Name and address of person who	completed cause of	death /!-	220) (7:	_		- 4			1/2		04	
	- '									1 0-1-					
	Stat	e	Dr. Gurdeep Chhabra, 31. Date filed (Month, Day, Year)	32. Regist	a s Signa	otch Roa			Maryla:	nd 20636					
	Registra	_	SEP ()	\$ 2004 > 6	Jan mary	101	front &	11							

	KKD		1- For Unpend Item 23a, pt.11,27,28a-I per me 6836 10 44-07 Certificate of Death	ental Hyg	giene	29811			
			Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death			
	Physici		Robert W. Eastridge	Month	Day Year 26.2004				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	AUGUST	4c. County of Death	1:32P. M			
	90		10411 CRANBROOK HILLS PLACE COCKYSVILLE		BALTIMOR				
S	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	Hrs. 8. Date of Birth 9. Birthplace (State or Foreign					
3	Director		218 44 1165 57 Yrs.	June 28	3, 1947 Vi	rginia			
	pu ≱		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			404 1-11-07-11-1			
	sho sho	5				10d. Inside City Limits 1 ☐ Yes 2 X No			
	with the Maryland is or 28a-f show Le notified at	Director	MD Howard Columbia  10e. Street and Number 10f. Zip Code		IO- Chines (140 - 1 O				
	with with	급	10411 Cranbrook Hills Place #G 21030		10g. Citizen of What Co				
	hours after death with the Marylan turel', or Items 23a or 28a-f show al Evanirer must be rollified at	Funeral		ecify Yes or No-	United Sta				
(0	or Iter	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 → Married 1 ▼ Yes 2 □ No	Rican, etc.)	Black, White				
93		l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1966-70		Specify:	White			
5-0	"natural",	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	ina	16b. Kind of Business/l	ndustry			
21		ldu	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)						
2	a filed within I Hygiene. other than		5+ Public Health Administ		State of Ma	aryland			
and	be fi	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name  Collegie E. Engthsei Bree						
Ž	d Mer narke natic	70	Calvin F. Eastridge Margaret  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run.						
Maryland 21215-0036	Pages 1 and 2 should be filed ent of Health and Mental Hygiv nt: If item 27 Is marked other ry or other traumatic event, II					p Code)			
			20a. Method of Disposition 20b. Place of Disposition (Name of		MD 21044 20c. Location - City or T	own. State			
<u>lo</u>			1 Burial 2X Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Crematory or other place)  Metro Crematory  8-27-		Catonsville				
Baltimore,	permit. Pag Department Important; I any injury o		4						
ñ	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee  Which is a signature of Funeral Service Licensee  Which is a signature of Funeral Service Licensee  Which is a signature of Funeral Service Licensee  4112 Old Columbia P:	ry H. WI iko Elli	cott City	MD 21043			
	1111111111		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of			Approximate			
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Subacute Subdural Hemorrhage  Subacute Subdural Hemorrhage			Interval Between Onset and Death			
	/Medical		disease or condition resulting in death)  Subacute Subdurat nemorrnage  Due to (or as a consequence of):						
ш	Examiner		Sequentially list conditions h						
4	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						
8760,	ate be executed hysician and he burial-transit		Due to (or as a consequence of):						
687	ate he	edical	d						
×		/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		22d Data of dolls				
Box	death e atter	clar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		23d. Date of deliv Month	Day Year			
P.O.	the che	Physician/M	9 Unknown						
		y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	the cause of death?			
rd	- ° 0	Completed by	Cardiomegaly	1 ☐ Ye	es 2□No 3□Pro	bably 4 Unknown			
900	awı is b	plet		24a. Was a		opsy findings available			
Ä	Th ate pag	Com		autops perform 1 X Yes 2	ned? death?	ompletion of cause of 2□ No			
/ita	S SE	Be (	25. Was case referred to medical examiner?						
of V	ys dil	2	1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5□Reside	nce 6 ther (Speci	fy) SCENE			
no On	fter frer	lon	1 Natural 5 Pending Found th, Day Year Found Work?		w injury occurred				
Sic	Attanding r death. actor: After	icat	2 Accident investigation 8-26-2004 1:00 P M 1 Yes 2 No	Unkno	VC3 17				
Division of Vital Records,	or A after Dirac in by	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	, State 0411 Cr	anbrook Hil			
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Diractor: A completely filled in by the fu		Scene  29a. Certifier  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and place are considered to the control of the cont		ockeysville	f			
	e Hos 24 h a Fur	edical	(Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	ate and place, and due t	o the cause(s)			
	ro th within ro th	₩.	29b. Signature and title of centifier 29c. License number	29	9d. Date signed (Month,	Day, Year)			
			Due 2 O.C.M.E.	7.17	וכדוכיד איז אינ	04			
(	W/X		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	JAC	IGUST 27,200	J' <del>±</del>			
_	~ JOV ~		ANA RUBIO, MD 111 Penn Street, B	altimore	e. Marvland	21201			
	Sta	-	31. Date filed (Month, Day, Year) AUG 3 0 2004 32. Agistrar's Signature		1				
	Registr	ạr	AUG D V ZUII4 James St. Small						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For WCHD/SH 9/13/04State of Maryland / Department of Health and Mental Hygiene State Amend Item #23a per Dr. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year September 0700 A M 4,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** tospital Baltimore 01 Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**XX**M 2□ F Days Hours 68 Director May 10 1936 281-30-6509 Usual Residence of Decedent Ohio the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Exercimer must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a 21742 19727 Marigold Drive U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3X Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 72 h and Mental Hygiene." 7 is markad other than "n Elementary/Secondary (0-12) College (1-4or 5+) Machinist 12 Aerospace Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hobart Edwards Cynie Steele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 19727 Marigold Drive Hagerstown Maryland 21742 Jack A. Edwards othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ŏ permit. Page Department of Important: If any injury or once. Smithsburg Crematory Sept 7 2004 Smithsburg Maryland 1 4 ☐ Donatie 5 Other (Specify) 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home Tr 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver tailure Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit The law requires that the death certificate be executed Kid neer Due to (or as a consequence of): P.O. Box 68760. the attending physiclan Chronic Lymphocytic Leukemia Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ Arateri Disease Heypertension 1 Yes 2 No 3 Probably 4 Honknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No Diabetes 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death Check on one examiner Hospital: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10 1908 1a rie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Relication Armus SHARIEF MOHAMMAD 31. Date filed (Month SEP) 32. Registrar's Signature State 08

DHMH 17 Rev 1/2001

Registrar

ducado, Ja

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 298 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Fields 03 2004 0 mes 4b. City, Town, or Location of Deeth 4c. County of Death 4a. Facility Name (If not institution, give street end number) Wicomico Hospice AT THE L OASTAL isbury 8. Date of Birth (Month, Dey, Yea 06-21-1925 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1⊠M 2□F SILOAM, MD. 79 219-14-4357 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No WICOMICO ALLEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3570 POST OFFICE ROAD 21810 USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 → No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PAINTER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLIFFORD FIELDS BEULAH SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) LULA LEE FIELDS - SPOUSE P.O. BOX 64 ALLEN, MARYLAND 21810 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRINGHILL MEM. GARDENS 109-07-04 HEBRON, MARYLAND 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 MIS 23a. Part 1. Enter the disease, or complications that caused the death bound enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 Ves 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

**Physician** /Medical Examiner

and

physician

**Physician** 

Examiner

**Funeral** 

Director

the Merylend

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryler Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23a or 28a-1 show any injury or other traumstic event, the Medical Evaninet must be notified at once.

Baltimore, Maryland 21215-0020

/Medical

10a. State

MD

Director

Funeral

ξ

Completed

Be

Examiner for use as the burial-transit Physician/Medical is certificate has been signed by the a director, page 2 should be detached þ Be Completed Medical Certification: To

25. Was case referred to medical examiner? 27. Manne of Death

1 Tes

1 Natural

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

2 No

Divisio	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu
	spita hours neral y fille
	he Ho in 24 he Fu pletel
	Vith Com

ter

ng Physician: The law requires that the death certificete be executed

of Vital Records, P.O. Box 68760,

State Registrar

Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carrie

SEP 0 3 2004

5 Pending

investigation

6 Could not be determined

32. Registrar's Signature

1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28a. Date of Injury (Month, Day Year)

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 LYes 2 No 1L Yes 240 No

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🚅 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** SEPTEMBER 6, LESTER WILLIAM FOLEY 2004 4:55 P M /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) **Examiner** GARRETT COUNTY MEMORIAL HOSPITAL GARRETT OAKLAND If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year AUG. 28, 1 Birthplace (State or Foreign Country)
 WV 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 234-14-5648 92 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nen of Health and Mental Hygiene.
sets if items 72 is marked other than "neturel", or items 23a or 28a-f show any or other traumatic event, if a Medical Examination safe by inclination. 1 ☐ Yes 2 No Director WV GRANT GORMANIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BOX 203 26720 RT. 1 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Gir Year or Dates: δ 3 Nidowed 4 □ Divorced Completed 15. Oecedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COAL MINER MINING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HOMER DeSOTO FOLEY DORA BELLE MANKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EILEEN WHITEHAIR - DAUGHTER P.O. BOX 66 GORMANIA, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 

Burial 2 

Cremation 3 

Removal from State permit. Page Department of Important: If any injury or once. BAYARD CEMETERY 09/09/04 BAYARD, WV 4 ☐ Donation 5 Other (Specify) 21. Signature of 22. Name and Address of Facility P.O. BOX 243 unera M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician DIABETIC KETO ACIDOSIS 2 WEEKS /Medical resulting in death) Due to (or as a consequence of). Examiner YEARS Sequentially list conditions, flary, leading to minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DIABETES MELLITUS Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 9 I Linknown signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 
☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2X No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 XNatural 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. М 2 Accident after death 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D15333 SEPTEMBER 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

THOMAS G. JOHNSON, M.D.

8 200#

SEP

31. Date filed (Month, Day, Year)

32. Registrar's Signature

311 N. FOURTH STREET

OAKLAND, MD 21550

,	Physici /Medic Examin	an al er
	Funeral Director	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment inter the notified at once.	To Be Completed by Funeral Director
B	Physician	

/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1 - For State Registrar	ale of Marylar	•	ificate of De			Reg. No. )	01	00010	
Decedent's Name (First, Middle, Last)					2. Date of Dea		U-y	3. Time of Death	
Robert Michael	Frankf	ırt			Month August	27 200	Yeer	8:25 AM M	
4e. Facility Name (If not institution, give street			4b. City, Town, or Lo		luguse		y of Death		
22680 Cedar Lane Ct.			Leonard			St	Mary	1 0	
5. Social Security Number 6. Sex	7. Age (In yrs.			Under 24 Hrs.	8. Date of Birt			place (State or Foreign intry)	
228-66-1069 ¹ <b>⅓</b> м	<sup>2□ F</sup> 54	Yrs.	Months Days I	Hours Min.	8. Date of Birt (Month, Da) Dec • 28			ntry) rginia	
Usuel Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loca	ition					10d. Inside City Limits	
Maryland St. Mary'	s	Leonardt	own		<u> </u>			1 ☐ Yes 2 📉 No	
10e. Street and Number			10f. Zip Code			10g. Citizen o	What Cou	intry?	
22680 Cedar Lane Ct.	, Apt.# 1	432	2065	0		USA			
11. Marital Status	Vas Decedent Ever in U	J.S. 13. Wa	as Decedent of Hispa res, specify Cuban, I	anic Origin? (Spe	city Yes or No-	- 14. Ra	ice - Ameri	ican Indian,	
1 Never Married 2 Married 1	X Yes 2    No f Yes, Give fear or Dates:			Specify:	moun, otc. j	1	ity: Wh:		
15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)									
Elementary/Secondary (0-12)	College (1-4or 5+)					3.6			
	1		Musician_	B. Mother's Name	/Fires \$diddle	Mus Mus			
17. Father's Name (First, Middle, Last)	1.6		10				uri <del>o</del> j		
	ıkfurt 				M. Bri			20650	
19a, Informant's Name/Relationship (Type, I			Address (Street and						
Katherine F. Powell			Lake & Br						
20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo 1 ☐ Donation 5 ☐ Other (Specify)	val from State Bri	Place of Disposit cemetery, ccema nsfield Cremate	-Echols	l i	,2004 C	20c. Location			
21. Signature of Juneral Service Lizensee		22 1	Name and Address of	of Facility	-		00		
	eld, Jr. MO	0052 L	rinsfield eonardtown	Funeral Maryl	and 206	50A.			
23a. Part1. Enter the disease, or complication	ons that caused the dea							Approximate Interval Between	
shock, or heart failure. List only one ca	ause on the line.	DE	0	0				Onset and Death	
disease or condition resulting in death)	Due to (or as a conse	avie	eccin	1					
	Due to (or as a conde	querice oi).	0	00	tur				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	uence of:	ces A	elle	Kus	) <u> </u>			
Cause (Disease or injury									
that initiated events c c	Due to (or as a conse	quence of):						4-2	
d									
	f yes, outcome of pregr	ancv				224 5	ate of deliv	40D/	
in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	eldeath 3□E	ctopic pregnancy Other (specify)				lonth	Day Year	
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	00atti 5 🗆 (	other (specify)						
Part II. Other significant conditions contribu	uting to death but not re	sulting in the und	ferlying cause given i	in Part I	23e. Did to	obacco use co	ntribute to	the cause of death?	
	oling to dealin out not re	salting in the unit	ionying oddao gwon	411 4111	101	V		bably 4 Unknown	
	ALC: 144 (A					270.110			
					24a. Was autop	SV	prior to co	opsy findings available ompletion of cause of	
					perfo 1 ☐ Yes	rmed? 202 No	death?	2 No	
25. Was case referred to medical			2	6. Place of Death					
examiner? 1 Yes 2 No Hosp	ital: 1 Inpatient 2	ER/Outpatient	3 DOA Other:	4 Nursing Hor	ne 5 Resid	dence 6 🗆 O	ther (Speci	ify)	
07.14	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	1	28d. Describe l	now injury occi	ırred		
1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	(Monin, Day 19al)	Injury		s 2 No					
3 Suicide 6 Could not be determined	8e. Place of Injury - At I	jorne, farm, stree	et, factory, office	1			ber or Au	ral Route Number,	
4 Homicide	building, etc. (Spec	ny)			City or Tov	vii, State)			
22. Adamser of Death 1. Natural 2	On the basis of examin	owledge, death o	occurred at the time, estigation, in my opin	date and place, a	and due to the	cause(s) and r	nanner as	stated. to the cause(s)	
	and manner stated.								
29b. Signature and title of certifier	4 -		29c. License n			29d. Date sign		, Day, Teal)	
Mon	Minh)		1)14	581		8-36	10Y		
30. Name and address of person who	eted cause of death (Ite	m 23a) (Type, P	rint)						
William D. Boyd II			t Lookout	Road Le	onardto	wn, Ma	rylan	d 20650	
31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	and a						
SEP 0 2 200	4	St A							

State

Registrar

6 Dr

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Mary Estelle Ford September 8, 2004 4:30 a.m. /Medical 4e. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayside Care Center Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 图 F Yrs Director 218-34-7294 84 31, 1919 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or Itams 23a or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 PNo St. Mary's Dameron Maryland Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 49395 Fords Lane 20628 death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married ☐Yes 2 f Yes, Give 2 😰 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ② No Specify: Specify: Black þ If Yes, Give Year or Dates: 3 ₩Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I 2 Albert Chase Agnes Lee Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health ar
Important: If Item 27 Is
any injury or other trau Cecelia Saunders / Daughter P.O. Box 2092, California, Maryland 20619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) St. Peter Claver 9-11-2004 Ridge, Maryland 21. Signature Funeral Service Consee Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician andioli /Medical Due to (or as a consequence 1): Examiner disect dio Vastulo Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attanding Physician: The law requires that the death certificate be executed reur C and Due to (or as a consequence of) burial-1 P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) the 9 Unknown à signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 DUnknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 💢 No Other: Medical Certification; To 4/ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA SIUI 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 12Natural 5 ☐ Pending death. 2 Accident investigation 1 Tes 2 No after death in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24435 Mervell Dean Road, Hollywood, Maryland 20636 Youngsik Moon, M.D., 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State SEP 0 9 Registrar

Michael Antoin Fort Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-05718 1- State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Reg. No. MAN 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Michael Fort Day **Physician** September 04, 0917 A M 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Clinton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Southern Maryland Hospital Center Prince George's Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12M 20F Months 16-08-198 **Director** 1454 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County I show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at 1 Tyes 2 PLNe Director 10g. Citizen of What Country? 10e. Street and Number 304 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Beltway GATage Deves ro man 18. Mother's Name (First, Middle, Maiden Sumanie) 17. Father's Name (First, Middle, Last) Be f Health and Mental I Item 27 Is marked of SACKSIN 10mmy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) For 7 BIOTHE 3326-Clrt.s 41 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Harman injury 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 2. Name and Address of Facility Junalsons 5635 11 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seizure Disorder **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 2 🗆 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an certificate has autopsy performed? 2□No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 XYes 2 No 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Injury 1 Natural
2 Accident 5 Pending 1 🗌 Yes 2 🗆 No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division

death. To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by

> State Registrar

CHINES

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only

> KORE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

September 05, 2004

MA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

O.C.M.E.

within 24 hours a To the Funerel C To the

State Registrar

30. Name and address of person

ted cause of death (Item 23a) (Type, Print)

and manner stated

O.C.M.E.

August 29, 2004

29d. Date signed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 28 2004 1920 Gordy 40181151 /Medical Elizabeth Anne 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PENINSULA REGIONAL NICOMICO 3AV136410 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛣 F Months Director 099-22-8835 75 February 7, 1929 New York Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 77 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, Its Medical Examinat must be notified at 10d. Inside City Limits 1X Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 200 Civic Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filad within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Bookkeeping parmit. Pages 1 and 2 should be filt.

De. artment of Health and Menfal Hy
Im. ortant: If item 27 is marked oth.

an Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Hambel Gordy Elizabeth Harry James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 10101 Bon Meade Lane, Cornelius, North Carolina 28031 Anne E. Conr 20a. Method of Disposition Conner (niece) 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory August 30, 2004 Salisbury, Maryland r. S. nature o Funeral Service Licensee 22. Name and Address of Facility Holloway FuneralHome Professional Association David 501 Snow Hill Road, Salisbury, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4SWD 24 CM Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-fransit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical usa as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown has been signed by ye 2 should be defact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes a No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificafe 2 No 1 Yes 1 Yes 2 No After this certification funeral director, Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death, investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours after To the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who wish D051359 August 30/5 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST STUSBURY DR. USIHA NATESAN 1415 S- DIVISION 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 3 1 2004

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 20022 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Septenth 7, Year Physician Frances F. Greenlees 6:25 /Medical 4b. City, Town, or Location of Death Williamsport 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Garden Terrace Assited Living Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 ☐ M 2X☐ F 78 082-20-7550 Feb.2.1926 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Md. 10e. Street and Number 21 16505 Virginia Ave. 1 ☐ Yes 2√2 No Williamsport 10g. Citizen of What Country? 10f. Zip Code 21795 USA Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1☐ Yes 2☐ No Specify: Specify. White Completed by 3 ☑Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wylie Fannie UK Joseph ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8900 Stauffer Rd. Walkersville, Md. 21793 19a. Informant's Name/Relationship (Type, Print) Kevin Greenlees son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sept. 11,2004 Westbury, NY Friends Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Burner Trade Services, P.A. 1037 Dual Place Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consquence of Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2√No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending

**Physician** /Medical Examiner use as the burial-transit The law requires that the death certificate be executed detached tate has been signed page 2 should be det Hospitel or Attending Physician: after death. Director within 24 hours a To the Funerel I completely filled

Funeral

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Pages 1 and 2 siment of Health an

Important: If ite eny injury or oth once.

other treumetic event, the Medical Examiner

ltimore, Maryland 21215-0036

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies bi cer who completed cause of death (Item 23a) (Type, P. Name and address 10/Hon ) 4 32. Registrar's Signature, 0 9 2004

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

investigation

6 Could not be determined

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

			partment of Health and Nertificate of Death	Mental Hygie	and the second
Physic /Medi		1. Decedent's Name (First, Middle, Last) Yolanda Valencia Glower		2. Date of Death Month August 30	Day Year 3. Time of Death 9, 2004 5:40 P M
be filed within 72 hours after death with the Maryland of that Hyglene.  ad other than "natural", or itams 23a or 28a-f show configuration in the Maddeal Examiner must be notified at or an examiner must be notified at or	Director	43. Facility Name (If not institution, give street and number)  4300 Saul Road  5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)  7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death  Kensington  // If Under 1 Year   If Under 24 Hrs.  Months Days Hours   Min.	8. Date of Birth (Month, Day, Ye Jan. 12,	4c. County of Death  Montgomery  9. Birthplace (State or Foreign Country)
		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or		Jan. 12,	10d. Inside City Limits
		Maryland Montgomery Kensing  10e. Street and Number  4300 Saul Road	10f. Zip Code 20895		1 ☐ Yes 2 ☑ No  Citizen of What Country?  USA
vithin 72 hours after do men. then "neturel", or item he Medical Exeminer.	ed by Funeral	1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	vadoran	14. Race - American Indian, Black, White, etc. Specify: White
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Deficilitions, Maryla permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 20b. Place of Disp	ematory or other place) Septe	niber 9 20c.	20895 Location - City or Town, State  Salvador, El Salvado
Dermit. Depert Import		22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901			
The law requires that the death certificate be executed by Medical be executed by Medical be executed by Medical be executed by Medical bear signed by the attending physician and an original by the print of the pr	Physician/Medical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
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	edical Certifi	28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Certifier (Check only) (Chec			
To the H within 24 To the F complete	Medi	29b. Signalure/and title of certifier	29c. License number  D45880	29d. C	hate signed (Month, Day, Year)  August 31, 2004
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_	5. Social Security Number	6. Sex 7	. Age (In yrs. last		f Under 1 Year	er Spr	24 Hrs.	8. Date of Birth	1	Montgo 9. E	Omery Birthplace (State or Fore Country)
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Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What	Country?
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Funeral	11. Marital Status 1 ▼ Never Married 2 Ma	Armed Ford		13. Was	s Decedent of H es, specify Cuba	ispanic Orig ın, Mexican,	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14	<ol> <li>Race - Ar Black, W</li> </ol>	mencan Indian, hite, etc.
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / De	epartment of H	ealth and Menta	al Hygiene

			1 - For State Registrar	State of Marylan		ent of He ate of D			iene og. No. () () ()		9826
	Physici	an	1. Decedent's Name (First, Middle, Last)	-				2. Date of Deat Month	h	Year	3. Time of Death
	/Medic			dore N. Geppe				August	30 2	004	1:40 P M
	Examin	ner	4a. Facility Name (If not institution, give s Gilchrist Hospice	treet and number)	4b. 0	_	Location of Death		4c. County o		
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Н	Director		190 32 0198 <sup>183</sup>	<sup>M 2□ F</sup> 62	Yrs. Mon	ths Days	Hours Min.	Month, Day, Dec 15,			sylvania
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location					11	Od. Inside City Limits
	Maryl -f sho	tor	MD Howard	F	llicott C	i +					1 ☐ Yes 2 🙀 No
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28s-f show ant, the Medical Eraminar must be notified at	by	1 ☐ Never Married 3 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1	1 □ Y€	s 2√2 No	Specify:		Specify:	Wh	ite
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODGs.		1 Substitution 2 □ Cremation 3 □ Records 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, crematory Louis C	or other place			Clarksv		
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	e Hospital or Attending Physician: 24 hours alter death a Funeral Director: After this certific etely filled in by the funeral director.		29a. Certifier 1 Certifying Phys	icien: To the best of my kno	wledge death occur	rred at the tim	e date and place	and due to the c	ause(s) and mar	nnerass	tated.
	ne Hoo n 24 h ne Fur	edical	(Check only 2 Medical Examination)	er: On the basis of examina and manner stated.	tion and/or investiga	ation, in my op	inion, death occu	rred at the time, d	ate and place, a	nd due to	the cause(s)
	To the within 2 To the I complete	Me	29b. Signature and title of certifier	1 -12		29c. License	number	2	9d. Date signed		
2	2		11. Anth	my Mile	), uro	U	7 %07	/	rtugu	ت /د	0,2004
10	y		30. Name and address of person who con	mplier cause of dea en	) ( 110 n 23a) (Type, Print) O 1 K. Ch	rle St.	Balto.	Md 212	407		
	Sta	te	31. Date filed (Month, Day, Year)	32. Figistrar's Signa	iture						

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Year August Glinger Lec 28, 2004 1310 4e Facility Name (If fot institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deef Baltimore Cite HOPKING HESPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. 1-15-1949 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2XF 579-62-8099 Maine Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Brookridge Drive 21713 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married & Married 1 ☐ Yes 2√ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Comptroller Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John F. Lee Helene Z. Comes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis W. Geiser/ Husband 703 Brookridge Dr., Boonsboro, MD 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2万Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 4 Donetion Kalas Crematory 9-2-04 Edgewater, MD 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 uu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): ARIDS - ACUTE RESpiratory Distress Syndrome 12 days Due to (or as e consequence of): Carcinoid Due to (or as a consequence of Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed?

**Physician** /Medical Examiner

ed by the attanding physician and detached for usa as the bunal-transit

After this cartificate has

complately filled in by the funarel director,

To the Hospital or Attendin within 24 hours after deeth. To the Funeral Director: Af

certificate be executed

of Vital Records, P.O. Box 68760

Division or Attending Examiner

Physician/Medical

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Completed

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Certification:

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**Funeral** 

Director

show

th and Mental Hygiene. 7 is marked other than "naturel", or frems 23a or 28a-1 shov traumatic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0036

Peges nent of h

6 injury

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

1 🗆 Yes 2 No 26. Piece of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 Yes 2X No 27. Menner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 5 Pending investigation

28b. Time of

28c. Injury at Work? 1 Tyes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

600 N worfe Street, Baltimore, MD 21287

Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

to Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) monoma Sanjon

6 Could not be determined

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Susan Alberta Goldsborough 8,2004 September /Medical 4a. Facility Name (If not institution, give street and number)
10805 Stately Oak Court 4b. City, Town, or Location of Death Examiner 4c. County of Death Waldorf Charles 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 🏖 F Director 213-56-7686 16,1949 Maryland Dec. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location rai', or itema 23a or 28a-f show Examiner must be notilied at 10d. Inside City Limits Director 1- Yes 2 No MD Charles Waldorf 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funerai 10805 Stately Oak Court 20601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. is! Hygiene. d other than "natural, or its event, the Medical Examin 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Cashier/ Clerk Federal Government Pages 1 and 2 should be filed w then of Health and Mentat Hygie trant: if Item 27 is marked other t jury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Elmer Alvin Rohls Agnes Cecelia Jones Rohls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Elmer Goldsborough/husband 10805 Stately Oak Ct. Waldorf MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State permit. Pages 1
Depertment of H
Important: If Ite
any injury or ot
once. 1 XBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial 09-11-04 Waldorf 21. Signature of Funeral Service Licensel M00817 22. Name and Address of Facility Arehart-Echols Funeral Home St. Mary's Ave. La Plata, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ESOP **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the ar 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After thi 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A 2 Accident filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, P 0 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **SEP 09** 2004 Registrar

		-	State of Maryland / Department of Health and  1- State of Maryland / Department of Health and  Certificate of Death		giene Reg. No?	20020
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ith	3. Time of Death
	Physicia		Evelyn Hazel Holliday	Month	Day Yea	10:40 A.M.
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deal	th	4c. County of De	ath
			SACRED HEART MOSPITAL Cumber and 5 Social Security Number 6 Sex 17 Age (In vis. last birthday) If Under 1 Year If Under 24 Hrs		111100	AN
	Funeral		1 M 2 F Wonths Days Hours Min.		7, Year) 9.8 1914 Pe	lirthplace (State or Foreign Country) nnsvlvania
L,	Director		218-50-0246 90 III.	riat 07	151-1 10	4
	ryland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	e Ma 3a-1 s	Director	MD Garrett Grantsville			
	with th		27 North Pennsylvania Avenue 10f. Zip Code 21536		10g. Citizen of What USA	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examination in Item Indianal and Once.	by Funeral	11. Marital Status  1	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, WI Specify: W	
Š	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	arkina	16b. Kind of Busines	ss/Industry
218	thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	,,,,,,,,		
2	filed with Hygiene other tha		8 th Homemaker	ma (Eirst Middle	Own Home  Maiden Sumame)	
Maryland 21215-003	2 should be filed won and Mental Hygie I's marked other traumatic event.	Be c		Catherine		
Ž	and Mental s marked o	၉	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R			, Zip Code)
<u>N</u>	and 2 sealth ar		Eva Lou Harman/daughter 2387 Accident-Bitting	ger Rd.,	Accident,	MD 21520
timore,	Pages 1 a nent of Hes int: If Item iry or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Addison Cemetery, Sept 7,	Date 2004	20c. Location - City Addison,	
Balti	permit. Departm Importa any inju		21. Signature of two all Service Censee  22. Name and Address of Facility Newman Funeral Hom 179 Miller St., Gr.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, of heart failure. List only one cause in each line.	ic or respiratory an	rest,	Approximate Interval Between
	Pnysician	a l	Immediate Cause (Final disease or conditions)	1/12	e ident	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
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	ted	nine	d ally, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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9	tificat ng phy as th	Medi	TESTIVALE.		William I was a second	1-2
Box	that the death certific. led by the attending pl detached for use as I	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1		23d. Date of o Month	lelivery Day Year
P. O	d by t	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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Vital Record	w requir been sì should l	Completed		24a. Was a	an 24b. Were	autopsy findings available
Re	he lav e has age 2	d mc			rmed? death	o completion of cause of ? es 2 No
tal	an: T tifficat tor, pi	e e	25. Was case referred to medical 26. Place of De	1 ☐ Yes eath (Check only or	340	55 20110
<u> </u>	Physiclan: r this certifica ral director,	To B	examiner?  1 Yes 2 746 Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing I	Home 5 ☐ Resid	lence 6 Other (S)	pecify)
ion of	Attending Pr r death. ector: After th by the funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  1 Yes 2 No	28d. Describe h	now injury occurred	
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	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date occurred at the time, date of examination and/or investigation, in my opinion, death occurred at the time, date of examination and/or investigation, in my opinion, death occurred at the time, date of examination and occurred at the examination at the examination and occur			
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			Mansal (hast 1 ND 0331	33	9/5/	64
			30 Name and address of person who completed dayse of death (Item 23a) (Type, Print)	Min	portan	mi
	St Regist	ate rar	31. Date filed (Month Pay, Year), 2004 32. Registrar's Signature		g - 100	

Disco			4 +1					ygiene Reg. No.	1 1 4 5	
Physic	ian	Decedent's Name (First, Middle,     TD ANGTO		TT TON			2. Date of D Month	eath Day	/ Year	3. Time of D
/Medi		FRANCIS  4a. Facility Name (If not institution,		LLTON	5 Ch. T-		Septem		7, 200	
Exami	ner	Prince George's			b. City, Town, or L Chever:		itn		County of Dea	
Funeral			6. Sex 7. Age (In yr	s. last birthday)	f Under 1 Year	If Under 24 Hr	s. 8. Date of B	irth	Prince 9. Bi	George's
Director		214-58-0013	<sup>1</sup> M <sup>2</sup> □F 53	Yrs.	fonths Days	Hours Mir	8. Date of B (Month, D May 10	1951	Mar	rthplace (State or F country) yland
*_		Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or Locati	ion					
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or 28e-f show	Director	10e. Street and Number	ocorge s		10f. Zip Code	S		10- 00		
38 or	0	6884 Walker Mil	11 Road # 204		20743				zen of What C	ountry?
ims 23a or 28e-f show	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. Was	Decedent of Hisp es, specify Cuban,	panic Origin? (	Specify Yes or N		. D . A . 14. Race - Am	erican Indian.
or its	Fu	1 ☑ Never Married 2 ☐ Marrie					rto Rican, etc.)		Black, Whi	ite, etc.
Fal.	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 2∏ No	Specify:			Specify:	Black
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ked ked ic ev	To Be	Thomas Allen					e Hamil		oomano,	
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Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f shov any injury or other traumatic event, If a Madical Examinar must be notified at once.		20a. Method of Disposition		Place of Dispositio	on (Name of		Date	20c. Loc	cation - City or	Town, State
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			1 - For State Registrar	State o	f Marylan		artmen <i>rtificat</i>			and M	lental Hy	giene Reg. No.	004	29831
	Physici	an	1. Decedent's Name (First, Middle, L								2. Date of De	ath Day	Year	3. Time of Death
	, /Medic		Minnie Virgir								Sept.	<u>7</u>	2004	7:16 P M
1	Examir	er	4a. Fecility Name (If not institution, g						Location of	f Death			ounty of Death	
	Francis		16731 Taylors L  5. Social Security Number 6.	anding R	Oad 7. Age (In yrs.	last birthday	Sha:	rpsbu	ing	24 Hrs.	8. Date of Bir		hington	
п	Funeral Director		578-24-2109	1 ☐ M 2 💢 F	88	Yrs.	Months	Days	Hours	Min.	08/20/	ly, Year)	Cou	place (State or Foreign ntry) VA
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	e-fsh	ctor	MD Washin	gton	Sha	rpsbu	g							1 ☐ Yes 2½ No
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "natural", or items 23s or 28e-1 show other treumatic event, the Medical Exertities right by rediffied at	by Funeral Director	10e. Street and Number	andina D			10f. Zip						n of What Cou	ntry?
	eath v	eral	16731 Taylors L		OBU edent Ever in U	C 12		742	anania Oria	in 2 (Cn	ecify Yes or No		US . Race - Ameri	and lading
တ	ifter d ir item idner	Fun	1 ☐ Never Married 2 ☐ Married	Armed Fo	rces? 2⊠No		If Yes, spec	city Cuba	n, Mexican	, Puerto	Rican, etc.)	14.	Black, White,	
93	ours a	1 by	3 ☑ Widowed 4 □ Divorced	If Yes, Giv Year or D			1 ☐ Yes	2√ No	Specify:			Sį	pecify: W	nite
21215-0036	"natu	Completed	15. Decedent's (Specify onfy highest g	Education rade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done d	lurina most	of worki	ng	16b. Kind	of Business/In	dustry
12	within iene.	omp	Elementary/Secondary (0-12)	College (1	-4or 5+)				, Operat	tor		Da	ta Prod	cessing
	other other	BeC	17. Father's Name (First, Middle, Las	st)			Jonipar		*		(First, Middle			cessing
<u>Jar</u>	Menta Menta arked atic e	ToE	John William Co	stello					Geo	orgia	a (unk)	Harr	ison	
Maryland	2 shc and ls m		19a. Informant's Name/Relationship		1								own, State, Zip	*
	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre-		Vickie Hahn / G	randdaug	<u> </u>	LD/3			Land		Road, S		burg, I	1D 21742
Jou	Pages nent of nnt: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec		State	semetery, crei t Have	matory or o	ther place			/2004			
Baltimore,	permit. F Departme Importen any injur		21. Signature of Funeral Service Lic	**	) Kes								stown,	neral Home
ä	permi Depa Impo any it		1/ Sun 4		<									21740
ō	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. MET  Due to	aused the death ach line.  ASTA for as a consequence of the line.	uence of):	Liv	عد	יות	FA	SE		· A	Approximate Interval Between Onset and Death 2 Mos
68760,	ificate be executed g physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to	or as a conseq	uence of):								
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	es that igned b	by P	Part II. Other significant conditions			ulting in the u	nderlying c	ause give	n in Part I.		23e. Did t	obacco use	contribute to the	ne cause of death?
ord	w requir been si should I	ted	HYPERT	FHSIC	),µ						10,	res 2 T	70 3 ☐ Prob	abiy 4 🗆 Unknown
Records,	elaw hasb je 2 st	Completed									24a. Was autop	an 2 sy med?	4b. Were auto	psy findings available mpletion of cause of
a	sician: Th certificate rector, pag		05.145								1 ☐ Yes	2 9 No	death? 1 ☐ Yes	2 No
Vital	Physician: this certifica ral director, I	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	npatient 2 🗆	ER/Outpatier	nt 3 DO	Othe			(Check only o		Other (Specif	
ot	ding Phys h. After this funeral di	T:u	27. Manner of Death	28a. Date		28b. Time of Injury		8c. Injury Work			8d. Describe			Y)
Division	or Attending after death. Director: Afte in by the fune	Certification:	1 Matural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine	on be 28e. Place	of Injury - At ho	ome, farm, str	М	1 🗆 ነ	'es 2 □ N		8f. Location (S City or Tov	Street and N vn, State)	lumber or Rura	i Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	one)	Physicien: To the eminer: On the ba and mani	best of my kno asis of examina ner stated.	wledge, death tion and/or in	vestigation,	in my op	inion, death	i place, a	ed at the time,	date and pla	ace, and due to	the cause(s)
1	Viit To Com	Σ	29b. Signature and title of certifier					License			-		igned (Month,	
	. *		+	the desired				1)3	191	2		9	109/	N.
_0	14.4		30. Name and address of person who Tulio 17 EMOCI		e or death (Item	1 23a) (Type,	CC CLL	M 7	ألمادرا	Più	£ 1600	100	1811.	mp 2 17UZ
	Sta		31. Date filed (Month SEP Year)		gistrar's Signa	iture	/ /	1-20	,		, - , - ,	ا عرا-	64	.,,

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Year 9:40 A M Neadurra Ellen Hall August 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Mary's Nursing Center Leonardtown

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Saint Marys 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 69 Yrs Director 215-36-2998 April 12, 1935 Maryland Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or 28a-f show or other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Saint Marys Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 24099 Hurry Road 20621 Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 8 Retail Clothes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Joseph Leo Bean Helen G. Redman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Paul Hall, Jr. / Husband 24099 Hurry Road Chaptico, Maryland 20621 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State injury ' 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 3, 2004 Bushwood, Maryland 21 Signature of Funeral Service Lice 22. Name and Address of Facility an A Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respirators shock or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Manusing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient s after dea. 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 ANatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C To the Hospifal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed Hollywood MD 20636 James P Jarboe Shah Assoc 31. Date filed (A) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 6:56 A<sub>M</sub> September 7, Julia Elizabeth Hill 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Marys Leonardtown Saint Mary's Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth
House Hours Min. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 87 1 □ M 2 K I F Yrs. 214-42-4175 Director February 12, 1917 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-1 show other treumatic event, the Medical Experiment must be notified at Director 1 Yes 2 □ No Bushwood Maryland Saint Marys 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 22952 Maddox Road 20618 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I house after Importent: If tiem 27 is marked other then "neturel", or flen eny injury or other treumatic awant. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Walter B Goode, Sr. Mary Jane Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Hayden / Daughter 22952 Maddox Road Bushwood, Maryland 20618 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 □ Cremation 3 □ Removal from State ° 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 2004 Bushwood, Maryland 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Kec disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1□ Yes 2□ 2<del>□ No</del> Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nefsing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred After Natural Z Accident 5 Pendina hours after death. investigation 1 Yes 2 No within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 | Homicide Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) To the ! 29b. Signature and title of certify 29c. License number 29d. Date signed (Month, Day, Year) 00 1) 19917 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr James C: Boyd M.D. Wildewood Shopping Center California, Maryland 20619 31. Date filed (Moching) 3 Registrar's Signature Registrar

			State Registrar	State of Marylar		artmen tificat			nd Me		giene Reg. No.	004	298;	34
	Physici	an	Decedent's Name (First, Middle, Last)	1 77					2	2. Date of Dea		Year	3. Time of	
	/Medic		Richard Edwa		11					Sept.			6:15	Ам
	Examin	er	4a. Facility Name (If not institution, give sti					Location of	Death			County of Deatl		
			1608 Earlham Av  5. Social Security Number 6. Sex	P . 7. Age (In yrs.	last hirthday)	If Under	Crof	ton If Under 2	4 Hrs. To	Date of Birt		ne Aru		-
	Funeral Director			<sup>1</sup> 2□F 69	Yrs.	Months	Days	Hours	Min.	B. Date of Birt (Month, Day ) ct.31	Year)	3/1 Wis	nplace (State o untry) CONSI	n Foreign
	ט		Usual Residence of Decedent				1			, , , , , ,	, 1 /	J4 WIC	COHSI	11
	ırylan show	<b>.</b>	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation							10d. Inside C	ty Limits
	Ba-f s	cto	MD Anne Aru	nde1	Croft	on							1 □XYes	2 □ No
	vith th	Director	10e. Street and Number			10f. Zip					-	en of What Co	untry?	
	s 23	eral	1608 Earlham Av				211					USA		
	Item	Funeral	11. Marital Status 12  1 □ Never Married 2 ▼ Married	2. Was Decedent Ever in U Armed Forces?	1	Yas Deced	ent of His	spanic Origi n, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	1	<ol> <li>Race - Amer Black, White</li> </ol>	rican Indian, o, etc.	
936	ursal al', o	by	3 □Widowed 4 □ Divorced	1 XYes 2 No If Yes, Give Year or Dates 1956	-82	I □ Yes	2 🕅 No	Specify:				Specify: Wh	ite	
Ö	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show I.s Modical Exacilies mast be malified at	Completed by	15. Decedent's Educa	tion	16a. Deced	lent's Usua	I Occupa	tion			16b. Kin	d of Business/l		
2	thin 7.	nple	(Specify only highest grade and Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT us	e retired)		or working	'				
7	ygier ygier har th	Co		5+	Ps	ycho						edicin	e	
and	be fi	Be	17. Father's Name (First, Middle, Last)	1 11						First, Middle,			_	
3	d Mer narke	ပ	Edward Willard		T							Woert		
Ma	d 2 sl th an th an traur		19a. Informant's Name/Relationship (Type Rita M. Hartzell					m Ave				Town, State, Z.		
Ġ,	Heal Heal tam 2		20a. Method of Disposition	20b. F	lace of Dispo	sition (Nan	ne of		e. Dat			MD. 2		
ē	ages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer `4 ☐ Donation 5 ☐ Other (Specify)	noval from State	cemetery, cren	-	•							
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic evant, the Modical Examinet required at ADDR.		21. Signature of Funeral Service License	ne ne	22	. T La I. . Name an	d Addres	s of Facility	B02	11 F.	Alex	xandri al Hom	a, VA.	
ä	Depa Impo any is		· Comm	Vouell	6.5	12 N	IW C	rain	Hwy	. Bo	wie.	, MD.	e 20715	
8760,	Physician /Medical Examiner bhysician and physician and the prinal-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to (or a))).									Onset and I	Rans
.O. Box 6	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	Ideath 3	Ectopic pre					23	3d. Date of deliving Month		'ear
S,	signed k	y P	Part II. Other significant conditions contr	buting to death but not res	ulting in the ur	iderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of d	eath?
ğ	w require been sig should b									1 □ Y	es 2	No 3□Pro	babiy 4 □U	nknown
al Records,	: The law racate has be page 2 sh	Completed	·							24a. Was a autops perform	sy i	24b. Were autoprior to condeath?	opsy findings a empletion of ca	ivailable iuse of
Vita	Physician: r this certificanal director,	Be	25. Was case referred to medical examiner?	spital:				~		Check only or	(e)			
	Phys r this ral di	2	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time of			4 U Nurs	sing Home	5 Reside		Other (Speci	fy)	
on	ding th. Afte fune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M	Bc. Injury Work	os 2∐No		a. Describe no	winjury	occurred		
Division of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funarel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre					. Location (Si City or Town	reet and n, State)	Number or Rur	al Route Numb	oer,
	To the Hospital within 24 hours a To the Funeral I	edical	29a. Certifier (Check only one)	tian: To the best of my knor: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a estigation,	at the time in my opi	e, date and nion, death	place, and occurred	due to the cat the time, d	ause(s) a ate and p	ind manner as solace, and due t	stated. to the cause(s)	
	To the within To the comple	Σ	29b. Signature and title of certifier	(10-1		29c.	License	number		2	9d. Date	signed (Month,	Day, Year)	
	(a) 111		1 yen	mu			000	29	57	/	09/	107/1	14	
CH	L (30) 160	1	30. Name and address of person who com	pleted cause of death (Item	23a) (Type-)	Print)	- 1	R.	10	Pon		in	2 2 .	
	Sta	to.	31. Date filed (Month, Day, Year)	■2. Registrar's Signa	ture	UFT	ON	IJLV	D.,	KUI	-10	N, 1/12	$\lambda$ , $\alpha$ /	14
	Registr	-	SEP 0 7 2004	Blow K	Con	81								

- 1	Funeral		5. Social Security N	Number	6. Sex	7. Age (In	yrs. last birtl	nday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of I	Birth	9. Birth	nplace (State or Foreign
	Director		129-12-	-6482	1 □ M 2 🕅 F	87	7 Y	rs.	Oct.	10,19	16Nor	nplace (State or Foreign untry) th Carolin
	p .		Usual Residence o			1						
	ylar how		10a. State	10b. County		100	c. City, Town	or Location				10d. Inside City Limits
	the Marylan r 28e-f show	cto	N.Y.	Bron	x			Bronx				1 X Yes 2 No
	or 28	Director	10e. Street and Nu	mber				10f. Zip Code		10g. Citiz	en of What Co	untry?
	death with the Maryland ms 23e or 28e-f show Tritual be poulified at		3544 E	Hollan	d Ave.			104	67	USA		
		Funeral	11. Marital Status		12. Was De Armed F		r in U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specify Yes or ban, Mexican, Puerto Rican, etc.)	No- 1	4. Race - Amer Black, White	
U.V.	within 72 hours after ene. then "naturel", or Ite	by	1 ☐ Never Marr 3 🔀 Widowed	_	If Vac G	2 🙀 No live Dates:		1 ☐ Yes 2K No			Specify: B1	,
7 / W D >	be filed within 72 hours la! Hygiene. d other then "nature!; event, Ital Medical Exa	Completed		cify only highe	it's Education st grade completed	·	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working ed)	16b. Kind	d of Business/I	ndustry
1/	d withing the result of the re	omo	Elementary/Seco 1 2		College	(1-4or 5+)		lurses aid	_	Hos	pital	
		(a)	17. Father's Name	(First, Middle,	Last)				18. Mother's Name (First, Midd		,	
	lid be lental rked c	0.8			John H	ood B	Beamar	1	Sarah Ga	tling		
cerca /		To	19a. Informant's N Dina Hi		ship <i>(Type, Print)</i> randdau	ghter			tand Number or Rural Route Num glade Lane #3			
Lac	of Her		20a. Method of Dis 1 🖫 Burial 2 4 🗆 Donation	Cremation	3 ⊠Removal from	n State		Disposition (Name of r, crematory or other pla wn Mem. C	100 00 04		ation - City or T	Jerse
, <u>;</u>	permit. Page Department in Importent: If any injury or		21. Signature of Fu	uneval Service	1963	all		22. Name and Addr		Funer	cal Ho	me
			23a. Part1. Enter i shock, or hea Immediate Cause	art failure. List	complications that only one cause on	caused the each line.	death. Do n	ot enter the mode of dy	ing, such as cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	on	a. Ne	o (or as a co	onsequence o	puctor	9 marce			
	Lammer	ē	Esquantially list conditions, gue to (of as a consequence of):									
	be executed ician and burial-transif	Examin	if any, leading to it cause. Enter Under Cause (Disease or that initiated event resulting in death)	5	5	die	rue	Calit	is			
69760	entificate be executed ing physician and e as the burial-transi		resoluting in death)	Last	d. Due to	o (or a a co	nsequence o	to when	tural Ble	edi	4	
	entificate ling phys	Medical	IF FEMALE:		1		0					

Laura Hinds

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Lanham

2. Date of Death

September Day

12004 12:26AM

4c. County of Death

Prince Georges

Division of Vital Records, P.O. Box To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, to

for use

been signed by the should be detached

has

Physician/M

by

Completed

Be

Certification:

Medical

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

SEP 0 7 2004

2 No

5 Pending investigation

6 Could not be determined

1 🗌 Yes

27. Manner of Death 1 Natural

2 Accident

3 🗀 Suicide

29a. Certifier

4 Homicide

(Check only one)

9 Unknown Part II. Other sight

5

State Registrar

1 - For State Registrar

**Physician** 

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

uting to death but not resulting in the underlying cause given in Part I.

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

29c. License number

1 ☐ Yes 2 ☐ No

3 Ectopic pregnancy

3□ DOA

М

28c. Injury at Work?

5 Other (specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

3 Probably

Year

4 Unknown

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No

24a. Was an

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed? 2 DAG

28d. Describe how injury occurred

31. Date filed (Month, Day, Year)

Hospital:

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death

1 Impatient

28a. Date of Injury (Month, Day Year)

9 Unknown

4☐ Pregnant at time of death

			Registrar  1. Decedent's Name (First, Middle,							and M tas	2. Date of De			1	3. Time of Dea	ath
	Physicia			osephine	Regina	Hill					Month AUGUS'	Г 26		ear 4	8:42 F	
	/Medic Examin		4a. Facility Name (If not institution,				4b. City,	Town, or	Location	of Death	1		County of		0.12 1	
			BAYVIEW MEDICA	L CENTER			BA	LTIM	ORE C	CITY			NONE	3		
	Funeral Director		5. Social Security Number 213 36 5359	5. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs. 65	last birthday Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept 1	rth ay, Year)		Coun	ace (State or Fo try) 11and	reign
			Usual Residence of Decedent			ty, Town or L						<u> </u>				i mai ka
	death with the Maryland ma 23a or 28a-f show r must be notified at	'n		-											0d. Inside City L 1 ☐ Yes 2∑	
	the M	Directo	MD Howar 10e. Street and Number	<u>.d</u>	El	licott	10f. Zip				-	10g. Citi	zen of Wh	at Coun	trv?	
	th with 23a or	0	2805 Dana Court					2104	.2		ĺ	_	nited		•	
	death with ma 23a oi r muni be	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.				igin? (Sp	ecify Yes or No Rican, etc.)		14. Race -	America	an Indian,	
36	or ite	by Fur	1 ☐ Never Married 2 【 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Ford  d 1 Tes  If Yes, Give  Year or Da	2 <b>5</b> (2) No		1 Yes 2		Specity:		rican, etc.)		Specify:	White, 6	™. Vhite	
Š	72 hours "natural", edical Ex		15. Decedent's			16a. Dece	dent's Usua	I Occupa	ation	et of work	ina	16b. Ki	nd of Busi			
215	within 7 ene. than "n he Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	kind of wor DO NOT us	e retired	iuring mos )	it of work	ing					
2	be filed within 72 ho Ital Hygiene. Ital other than "natur event, the Medical	Con	12			5	ecret	ary			( <del>-</del>				cy School	ols
Maryland 21215-0036	ould be fil Mental H arked oth atic even	Be	17. Father's Name (First, Middle, L. William J. Brook								e (First, Middle Mary Ma		Sumame)			
7	ges 1 and 2 should be t of Health and Mental if Item 27 is marked or or other traumatic ev	၉	19a, Informant's Name/Relationshi			19b. Mail	ng Address	(Street a			al Route Numb		r Town, St	ate, Zip	Code)	
	and 2 sauth ar n 27 is ier trau		Ian T. Hill/Hush	_							ott Cit				,	
re,	of Health of Health fitem 27		20a. Method of Disposition			Place of Disp	osition (Nan	ne of			Date	•	cation - Ci		wn, State	
E	Page nent o int: if		t ☐ Burial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Specific Control of Cont		tate	tro Cr	· .	•	-	3-27-	-2004	Cato	onsvi	lle,	, MD	
Baltimore,	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service	censee	101044										lly FH I MD 2104	
	_		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that ca	used the dea								LL CI	Ly,	Approximate	
	e Priysician		Immediate Cause (Final disease or condition								inhala				Interval Betwee Onset and Deat	
	/Medical Examiner		resulting in death)	Due to (d	or as a consec	quence of):										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (d	or as a conse	quence of):										
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events	c												
760,	be executed sician and burial-transit		resulting in death) Last	Due to (d	or as a conse	quence of):										
687	9 % 9	edical	ï .	d												
χ e	eath certific attending p for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								2	23d. Date of	of deliver	ν	
S. Box	requires that the death certifica een signed by the attending ph nould be detached for use as th	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 □ Feta ant at time of a wn		□Ectopic pro □ Other (sp						Month		Day Year	
P.0	that the		Part II. Other significant condition	s contributing to de	ath but not re	sulting in the t	ınderlying ca	ause give	en in Part I		23e. Did t	obacco u	se contribi	ute to the	e cause of death	1?
ds,	uires sign Id be	d by									10	Yes 2[	□No 3	☐ Proba	ıbly 4 <mark>∑</mark> Unkr	nown
COL	> 0 0	lete									24a. Was	an	24b. We	re autop	sy findings avai	lable
Vital Records,	lhe age	Completed			<del></del>						auto perfo	psy ormed? 2 2 No	dea	ith?	ipletion of cause 2 □ No	) ol
ital	ician: 1 certifica rector, p	BeC	25. Was case referred to medical			· · · · · · · · · · · · · · · · · · ·			26. Place	of Death	(Check only			7103		
of V	d is	2	examiner? 1X1 Yes 2 □ No	and the second s		ER/Outpatie				ırsing Ho	me 5□Resi	dence 6	Other	(Specify)	)	
D C	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date o (Month		28b. Time of Injury		8c. Injury Work			28d. Describe		y occurred			
Sio	Attending r death. sctor: After by the fune	icati	Accident investigation of Could not a could not be	at be		unkno		1 🗆 \	res 2 <b>X</b>		house i		d Mumbar	ar Ouml	Cauta Mumbar	
Division	al or At s after o	Certification:	4 ☐ Homicide determin	buildin resid	of Injury - At h g, etc. <i>(Speci</i> l <b>ence</b>	iome, iarm, si ify)	reet, factory	, опісе			City or Tol	wn, State, <b>t Ci</b>	2805 ty, l	Dan Mary	Route Number, a Court Land	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the in xaminer: On the bat and mann	sis of examin-	owledge, dea ation and/or in	h occurred avestigation,	at the tim in my op	ie, date an pinion, dea	nd place,	and due to the	cause(s)	and mann	er as sta	ited.	
	To the within 2 To the comple	Me	29b. Signature and title of certifier		_		290		number				e signed (/			
			Josha B	Succe	ne	0		0	CMI	$\Xi$		AU(	GUST	27,	2004	
			30. Name and address of pers w													
			Tasha Z-Greo 31. Date filed (Month, Day, Year)	nberg 1 92. Re 2004	1.D		11	1 Pe	nn St	reet	, Balt	imore	e, Ma	ryla	nd 2120	1
																-

DHMH 17 Rev 1/2001

ORIGINAL

WILLIAM A. HAYES

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For Stata Registrar		naryland	•	tificate of			F	Reg. No.	11	200	30
Physi	iciar		Decedent's Name (First, Middle, Las							Date of Dea Month	Day	Year	3. Time	
/Me Exan	dica		William Alfred F  a. Facility Name (If not institution, give 121 CARROLL DR		r)		4b. City, Town, ANNAF			AUG.	30, 20 4c. County ANN	of Death	D83 NDEL	0 A <sup>M</sup>
Funer Directo			230-20-8980	9x 7. A	Age (In yrs. lasi 77	t birthday) Yrs.	If Under 1 Year Months Days		vin.	Date of Birth (Month, Day Dril 5	Year)	9. Birth	place (State intry) hingto	or Foreign
ith the Maryland or 28a-f show		1	Usual Residence of Decedent 10a. State 10b. County  Maryland Anne Ar	rundel	10c. City, 7	Γown or Lo		Annapoli	is				10d. Inside (	City Limits
th with the 23a or 28		ם ב	10e. Street and Number 121 Carroll Driv	æ			10f. Zip Code	21403			10g. Citizen of U.	What Cou	intry?	
Dealt III Despired in the Maryland Color of the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination must be martified at		2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Deceder Armed Forces XIX Yes 2 [ If Yes, Give Year or Dates	s?		Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 🔀 No		? (Specify uerto Ric	Yes or No- an, etc.)	14. Rad Bla Specil	ce - Amer ck, White	ican Indian, , etc. nite	
thin 72 ho e. "netur Medical		najaldiiioo	15. Decedent's Ec (Specify only highest gra			(Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of ed)	working		16b. Kind of B	usiness/li	ndustry	
ed wi		5 -		4		E	Builder					truc	tion	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental the Men	c c		17. Father's Name (First, Middle, Last) Alfred William H	ayes						crown	Maiden Sumar	ne)		
2 sh and ls m			19a. Informant's Name/Relationship (			19b. Mailir	ng Address (Stree	t and Number o	r Rural R	oute Numbe	r, City or Town	State, Zi	p Code)	
C, IV		-	Buckley Hayes/so	n			Carroll I	rive A	nnap	olis.	MD 21	403	oum State	
Pages tment of tent: If Ike			1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	) 1	te cem	ietery, crer imore	natory or other pla e Cremato	rv 9/	2/20	04	Baltim	nne	MD	
permit. Departr Importa	once.		21. Signature of Funeral Pervins Licen	See Vil	1/00	1 /	2. Name and Addr	ess of Facility	John	M. Ta	aylor F	unera	al Home	е
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	olications that caus	ed the death.		7 Duke of dy	ing, such as car	diac or re	spiratory arr	rest,	lis,	Approxima Interval Be Onset and	ate etween
Physicia /Medic			disease or condition resulting in death)	a. Office	as a consequer	ANCIE	- Cuchi	mys int	~ 0	heen				
Examine	er				23 & 0011304401	100 01).								
P =		20	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequer	nce of):								
and trans			Cause (Disease or injury that initiated events resulting in death) Last	c										
ritificate be executed ng physician and set the burial-transit				Due to (or a	as a consequer	108 01):								
do /	1	wed ica		. d										
The law requires that the death cert the law requires that the death cert are been signed by the attending age 2 should be detached for use a	1.5	=	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of deat	ath 3	Ectopic pregnand Other (specify)	ру 				te of deliventh	ery Day	Year
law requires that as been signed b	3	y y	Part II. Other significant conditions of	ontributing to death	but not resulting	ng in the u	nderlying cause g	iven in Part I.		_	bacco use con	tribute to 1		death? Ùnknown
aw rec		najaidillo								24a. Was a			opsy findings	
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ysicle s cert direct		0	examiner? 1X Yes 2 ☐ No	Hospital: 1 ☐ Inpa	tient 2□EP	VOutpatien	nt 3 DOA	L			ence XX th	er (Sneci	fv) am	COTATI
ng Phys ter this neral di			27. Manner of Death	28a. Date of Ir (Month, L		Bb. Time of					ow injury occur		y) AT	SCENE
Attending at death. ector: Afte by the fune			1 Natural 5 Pending 2 Accident investigation	1		,,		Yes 2□No						
To the Hospitel or Attending Physicien: To the Hospitel or Attending Physicien: To the Funerel Director: Atten this certifica completely filled in by the tuneral director,		Certifications	3 Suicide 6 Could not be determined	289. Place of	Injury - At home etc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f.	Location (S City or Town	treet and Numb n, State)	er or Run	al Route Nur	nber,
he Hospi n 24 hou hs Funer pletely fill		edical	29a. Certifier (Check only one)  1 Certifying Ph	ysicien: To the be- niner: On the basis and manner	of examination	edge, death n and/or in	n occurred at the t vestigation, in my	ime, date and p opinion, death o	lace, and occurred a	due to the cat the time, d	ause(s) and ma late and place,	anner as s and due t	stated. o the cause(	s)
with To t	1	Σ	29b. Signature and title of certifier	. 10				se number		2	29d. Date signe			
•			I broken s	1, lary ~	es)			.M.E			AUG.		2004	
			30. Name and address of person who THEWOOF MIKE	completed chase of	deall (Item 2:	3a) (Туре, <b>1 Pen</b>	n Street	, Balti	more	, Mary	vland 2	1201		
	Stat	-	31. Date filed (Month, Day, Year)  SEP 0 2 26	32 Aegis	strar's Signatur	. /	- 10 -							
Regi			SEY V 4 L	TUT JUGG	W Jr	140	all .							

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Harried 29 2004 Aug. 11:40 Ma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Anne Arundel Medica1 Center <u>Anne</u> **Arundel** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 17☑M 2□F Director 29 81 1923 215-16-1949 Aug. Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 28a-f show Directo 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4742 A Flanders Lane 20776 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1942-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black. 1 ☐ Yes 2 ☐ XNo Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Harried ဥ Rachel Sellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felicia Harried (Wife) 4742 A Flanders Lane Harwood, Md. 20776 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition 20c. Location - City or Town, Slate X⊠Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 9/3/04 Cemetery 22. Name and Address of Facility Crownsville, Md. 21. Signature of Funeral Service Licensee Law Reese West & Sons MOrtuary Annapolis, M A. Treese Mo078 Sť 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COTO nagu /Medical Due to (or as a consequence of): Examiner Rechercier Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Mila The law requires that the death certificate be executed burial-transit Domen been signed by the attending physician and should be detached for use as the burial-tran Due o (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has page 2 autopsy 1 Yes 2 2 No or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation Injury 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier completely and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) UD 40519 8 31 104 30. National address of person who completed cause of death (Item 23a) (Type Print) noth 31. Date filed (Month, Day, Year) egistrar's Signature 0 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Month Year 8:10 art Irwin AM 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Madral enta Mapales MD Anne If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□F Days Hours Min -18 82 Yrs 021 Director MICHIGAN Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or Items 23s or 28s-f show treumstic event, the McCleal Examiner must be motified at Director 1 Yes 2 No Maryland | Anne Arundel Arnold 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1445 Middle Way 21012 Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1943–47 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Importent: If item 27 Is marked other than." Elementary/Secondary (0-12) College (1-4or 5+) Dep't. of Defense 4 years Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver Irwin Mildred Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1445 Middle Way, Arnold, MD Helena Irwin/ Wife injury or other 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kalas Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 9-1-04 Edgewater, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home any ir 2973 Solomons Island Rd. Edgewater, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 51 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** dash Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury months Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physicien Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 2 No 1 Yes 2 XXV 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Dipatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending Vatural Injury investigation 1 Yes 2 🗆 No 2 Accident 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, Hospitel or Attending Physicien: filled in by the funeral director, after death Director: within 24 hours

> State Registrar

Medical

29a. Certifier

(Check only one)

ana

29b. Signature and title of certific

L

Horton 31. Date liled (Month, Day, Year) 2004 0

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

B0057985

Ste 211

29d. Date signed (Month, Day, Year)

		1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>			giene Reg. No. 0	41 000	29841
Physicia		Decedent's Name (First, Middle)     Dale David	1	4.4.			2. Date of De Month	ath Day	Year	3. Time of Death
/Medica		Dale David  4a. Facility Name (If not institution,			4b. City, Town, or	Location of Dea		29, 200 4c. County		10:15 a M
LAGITATIO	-	20508 Watkins	-		German		atti		tgom	
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday)			s. 8. Date of Bir	th.		place (State or Foreig ntry)
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r 28a	Director	10e. Street and Number	-9	ROCKVIII	10f. Zip Code			10g. Citizen of V	Vhat Cou	ntrv?
23a o	a D	15316 Manor Vi	llage Lane		20853	3		USA		
ems L	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (	Specify Yes or No	- 14. Rac		can Indian,
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tice	2	Vaughn Kerstett	er			Emma	Murray			
E E E		19a. Informant's Name/Relationsh			ng Address (Street a					
m z/ her tr		Joanne K. Hull,	Daughter		8 Quick F	-	-			
or of		20a. Method of Disposition  1	3 □Removal from State	20b. Place of Dispo	osition (Name of matory or other place Heaven		tember 1   004	20c. Location -		
jury		`4 □Donation 5 □ Other (Sp		Cemeter	ry					g, Marylan
any injury or ot		21. Signature of Funeral Service L	lcensee	F <del>f</del>	ancis J. 30 Univer:	Collins sity Blv	Funeral	Home Ir ilver Sp	c. oring	, MD 2090
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for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy				e of delive	*
detached	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	t time of death 5	Other (specify)			Mor	1(1)	Day Year
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=	0	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital:	ent 2 ER/Outpatier	nt 3 DOA Othe		Home 5 Resid			Residence
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ı ya ı	Certification	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tox	treet and Numbern, State)	er or Rura	I Route Number,
pelli		00- 0-46 4 <b>5</b> 0-46-					10			
stely f	edicai	29a. Certifier 1 A Certifying (Check only one)	Physician: To the best xaminer: On the basis o and manner sta	i examination and/or in	h occurred at the tim vestigation, in my op	e, date and plac inion, death occ	e, and due to the ourred at the time, o	ause(s) and mai late and place, a	nner as si nd due to	tated. the cause(s)
	Med	29b. Signature and title of certiler	1 /		29c. License			29d. Date signed		
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and the same of	ŀ	30. Name and address of person w	no completed cause of d	leath (Item 23a) (Type.				August	30,	2004
		Richard P. Del			ara Drive	e, Silve	r Spring	, MD 209	906	
Stat		31. Date filed (Month, Day, Year)		ar's Signature						
legistra	ir	SEP 0 1	2004	we to be	ORNER					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Edward Yeer Keeler September 15, 2004 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Western Maryland Hospital Center Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1XM 2□ F 716-07-8928 Nov. 19, 1911 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Orange Orlando 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1165 Jessamine Lake Ct. 32839 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ College Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Keeler Florence M. Maybery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Keeler/Son 32 Manor Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 9/16/2004 Smithsburg, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses 1601 Pennsylvania Ave. Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OBSTRUCTIVE PULMOWARY DISEASE MRONIC disease or condition resulting in death) 30 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 21 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient 1 ☐ Yes 2 1 No Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 SNatural 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) P52323 · Jule 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue CIA MINIBARON Hagerstown, MD 21742

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, use as jo signed by the a page 2 certificate has filled in by the funeral director. after death. To the within 2

**Physician** 

/Medical

**Examiner** 

Director

by Funeral

Completed

Funeral

Director

r then "natural", or Itams 23a or 28a-f show Its Medical Examinar mast be notified at

marked other then

12 should be f h and Mental F

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permit. Page Department of Important: If any injury or

**Physician** 

/Medical

Examiner

physician and s the burial-transit

Examine

Completed by Physician/Medical

Be

Medical Certification; To

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registras Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ruth C Kleinwachter **Physician** Month Year Sept. 3, 2004 0742 am M /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Health and Rehabilitation Denton
If Under 1 Year If Under 24 Hrs. Caroline 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 12/7/1920) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 Yrs Director 83 420 12 7393 Sylacauga Al Usual Residence of Decedent with the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at Federalsburg Caroline Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 2731 Owens Drive, Federalsburg 21632 USA or Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Item any injury or other traumatic event, the Medical Examination. Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes X No Specify ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Years Postmaster US Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John L Hammond Annie Edwards Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 Meadowbrook Rd. Federalsburg, MD 21632 Carol Moore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat Irom State Junior Order 9/7/04 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Preston 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Framptom's 216 N. Main St. Fed Md 21632 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Ovarian Caricinoma Months disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): attending physician Box 68760 lan/Medicai IF FEMALE 23c. if yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year Physicia 5 Other (specify) P.O. | the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. q 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes No 2 0 No Physicien: Be 25. Was case relerred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funerai 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Hospitei or Attending 5 Pending after death. 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/03/04 D00053094 Attending MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bloomisdale Ave, Federalsburg, Md 21632 31. Date liled (Month, Day, Year) SEP 0 9 32 Registrar's Signature State 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HELEN ELIZABETH LORD SEPTEMBER 12 2004 1:50PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 613 DIXON TAVERN ROAD BARCLAY QUEEN ANNE'S If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F 212-20-5497 Yrs. JAN.15,1925 **Director** 79 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location Show 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic evant, the Madical Examinar rivest be recified at 1 ☐ Yes 2 X No MD QUEEN ANNE'S CENTREVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 RENAISSANCE CHASE 21617 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or item any injury or other traumatic event, the Madical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo WHITE Specify: ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **MERLE** GALL HELEN MARGARET CREIGHTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN MARGARET FELGENHOUER/DAUGHTER 118 KIDWELL AVENUE, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State OLD WYE CHURCH CEMETERY 9-16-2004 WYE MILLS, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBIEN & NEWNAM FUNERAL HOME, ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eause on each line. 408 S. LIBERTY ST., CENTREVILLE, MD Part1. Enter the disease, or complicate shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Clode **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 menths? Day Year 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be 2 10 No 3 Probably 4 Unknown 1 ☐ Yes Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) GRANDDAUGHTERS To Other: 4 Nursing Home 5 Residence 6 Other (Specify) RESIDENCE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. М 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 1510 12988

8 UL State

31. Date filed (Month, Day, Year)
SEP 1 6 200

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DAVID H. SMITH, M.D., 29466 PINTAIL DRIVE, SUITE 5, EASTON, MD 21601

TE	) <b>.</b> LL	VCC	JLIN  1 - For State Registrar	State of Marylar		artment of He			ene	20016
		٠	Decedent's Name (First, Middle, Last)				- Cat.	2. Date of Death	1	3. Time of Death
	Physici /Medic		Louis John	Lincoln, Jr.				SEPT.	3, 2004 Year	12:16 PM
*	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or I	ocation of Death		4c. County of Deat	h
			3101 APPLE CREEK		land block do A	WALDOR	If Under 24 Hrs.		CHARLES	
	Funeral Director		370 00 3770	7. Age (In yrs. 46	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 2,	Year) Co	hplace (State or Foreign untry) Shington DC
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Mary First	tor	Maryland Charles			Waldorf				1 ☐ Yes 2XXNo
	n the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	23a c	rai	3101 Apple Cre	ek Lane		2060	03	U	Inited Stat	ces
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	Obvesio		1. Decedent's Name (First, Middle, La	ast)				2. Date of Death Month		3. Time of Death	
	Physici /Medi		John Robert	Lester Sr	•			August	31, 2004	1:10 P <sup>M</sup>	
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	h the	Director	10e. Street and Number		1	10f. Zip Co		10	g. Citizen of What C	ountry?	
	th wil		21679 Susan Lan	e Apt.A		2	0653		USA		
	swe	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent	of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am		
စ္တ	or it	F	1 Never Married 2 Married	1 XYes 2 ☐ t	No	1 ☐ Yes 2 🔀		nican, etc.)	Black, Whi		
8	urel',	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:					Specify:	White	
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Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28e-f show with jaiury or other treumatic event, the Medical Examinar must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	)+)	. DO NOT use re olice Of	•		D C Motr	o Police Dep	
0	filled Hygi Hygi sther	Ö	17. Father's Name (First, Middle, Las	()		71100 01	18. Mother's Name			o rorree ber	
an	d be antal ced c	To Be	William T. Les	ter				nor Coyl	The state of the s		
<u></u>	Shoul nd Ma mari	Ĕ	19a. Informant's Name/Relationship		19b. Ma	iling Address (St	reet and Number or Rura			Zin Code)	
S	od 2 illih ar 27 is r treu		Louise M. Davis/		634		ard Club Dri				
ē,	s 1 al f Hea ltem othe		20a. Method of Disposition		20b. Place of Dis	position (Name o	of D		0c. Location - City or		
Ë	Pege ento nt: If ry or		1   Burial 2 □ Cremation 3   Comparison 5 □ Other (Special Compar		MD Veter	ematory or other		2004	Crownsvil	la MD	
Baltimore,	mit.		21. Signature of Funeral Service Lice				ddress of Eacility				
Ö	Depa Impo eny k		1 KILK	P		16000 A	Rob nnapolis Ro	ert E. E ad Bow	vans Fune: ie, Md 20	ral Home 0715	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each lin	the death. Do not e					Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		taitatic	nao	Samuel (41)			Onset and Death	
Ž.	/Medical		disease or condition resulting in death)  The transfer of the consequence of:  The transfer of the consequence of the consequen								
Н	Examiner		Sequentially list conditions								
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	ecute and trans	cam	that initiated events resulting in death) Last	C							
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87	cate physi the t	dicai	•	d							
9 X	ding	an/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						
Box	eath certific attending p I for use as	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregna			23d. Date of de Month	ivery Day Year	
o.	that the de ted by the a detached t	Physici	1 ☐ Yes 2/☑ No 9 ☐ Unknown	9□ Unknown			/				
<b>Q</b>	res that igned b	by Pi	Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying cause	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
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CO	s been si should	Completed						24a. Was an	24h Were au	itopsy findings available	
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0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injur (Month, Day	y Year) 28b. Time Injury			8d. Describe how		siry /	
jo	andin ath. or: Af	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	nijury		1 ☐ Yes 2 ☐ No				
Division of	l or Attenuafter deatl	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Inju- building, etc	Iry - At home, farm, s :. (Specify)	treet, factory, offi	ice 2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,	
	iltal o										
	e Hospital 24 hours a e Funeral etely filled	edical	(Check only 2 Medical Exa	miner: On the basis of	examination and/or i	th occurred at the	e time, date and place, a ny opinion, death occurre	nd due to the caused at the time. date	se(s) and manner as	stated.	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	one) 29b. Signature and title of certifier	and manner sta	ted.						
	M N		250. Signature and title of certifier	- M	0		9 5069 G	290	Date signed (Monti		
				•			30000		- / 5110		
			30. Name and address of person who	hyabih	Path (Item 23a) (Type	Print) うとも。 M	edical lenker,	HOLLYWA	1 M 00		
	Sta	te	31. Date filed (Month Day, Year)		ur's Signature						
	5		SEPUTA	UU4 Alex	- H	C- 10 -					

DEVON A. MOSES Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK 04-286 State of Maryland / Department of Health and Mental Hygiene 04-05502 1 - For State Registrar Certificate of Death 2001 RJ Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** 26. 0140 A August 2004 Alexander Moses /Medical Devon 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Salisbury Wicomico County Route #13 North of Liberty Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** June 4, 16 Maryland Director 213-29-9002 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic evant, If the Madical Examiner must be notified at 1⊠Yes 2 □ No Director Salisbury Maryland Wicomico 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ö 21804 USA or Itams 23a 212 Eden Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, If a Marical Examination. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 Widowed 4 Divorced Year or Dates: African American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) 9 Student 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Moses, Sr. Joyce Ann Walker Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (father) 212 Eden Street, Salisbury, Maryland Alexander Moses, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery Sectember 4, ALM Salisbury, 22. Name and Address of Facility Holloway Funeral Home Professional Association Policy Funeral Home Professional Association 21804 Donation 5 ☐ Other (Specify) 702 Savice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multi **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown been signated the Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? death? 2 🗆 No 2 No certificate the Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) At Scene 1 X Yes 2 □ No 2 this After this funeral d 28a. Date of Injury Month, Day Year) 28b. Time of Injury A 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: occupant of a vehicle struck 5 Pending investigation Natural 1:35 126/04 1 ☐ Yes 2XNo Steel bride Aud elected

281. Location (Street and Number or Hural Route Number,
City or Town, State) М 2 Accident after death Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Salis bury 4 | Homicide

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

OCME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) August 26, 2004

Route 13 NIBAST rect

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

street

within 24 hours a
To tha Funaral C
completely filled i

			For State Registrar		ryland / Dep		f Health and	Mental Hygi	•	29849
DI	nysicia	20	1. Decedent's Name (First, Middle, Las					2. Date of Death	Day Year	3. Time of Death
/	Medic	al	GRACE LARUE MARP						ER 5, 2004	
E	xamin		4a. Fecility Name (If not institution, give GOODWILL MENNONI	TE HOME		GRANT	n, or Location of Dea		4c. County of Dea	
	neral ector		5. Social Security Number 6. Security Number 232–42–5970	9X 7. Age □ M 2X F 87	(In yrs. last birthday 7 Yrs.		ear If Under 24 Hr ays Hours Mir		Year) 9. Bir 1917 P	thptace (State or Foreigr ountry) A
/land	1		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Mar A	diffed	ctor	MD GARRET	T	OAKLAND					1 ☐ Yes 2 No
5-0036 72 hours after death with the Maryland	idential, of reflix of constant	by Funeral Director	10e. Street and Number			10f. Zip Coo	de	10	g. Citizen of What C	ountry?
ath w	Table 1	rai	20943 GARRETT HI	<del></del>			550		USA	
ter de	i i	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🗓 No		tf Yes, specify (	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Am Black, Whi	
036 urs af	Exam	by f	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:		Specify:	WHITE
215-0036 Ithin 72 hours aff	lical	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Dec	edent's Usual Oc	ocupation	arkina 1	6b. Kind of Business	/industry
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Maryland 212- nd 2 should be filed within the and Mental Hygiene.	9A 9 3	o Be	JOHN CLARE	NCE PHIL	LIPPI		MARGA		•	OLF.
2 should	or other treumatic event, the M.	၉ .	19a. Informant's Name/Relationship (T			ling Address (Str	1	Rural Route Number,		
- m	rtre		JOHN MARPLE - SO	N	1	. BOX 1		NRY, MARYL		
ore, M es 1 and 2 of Health	a t	1	20a. Method of Disposition		20b. Place of Disp	osition (Name o	f place)	Date 2	0c. Location - City or	Town, State
Page Page	i d		1 XBurial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify)			CEMETE		r 8, 2004	ADDISON,	PA
Baltimore, perrit. Pages 1 a Department of Hee	any injury or oth		21. Signature of Funeral Service Licente				tdress of Facility NEKAL HOME	P.O. B		50
Exan		ical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Chron Due to (or as a	consequence of):  Consequence	l fail	me			years 12 years
SOX of ath certification	be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetat death 3	□Ectopic pregna □ Other (specify			23d. Date of del Month	ivery Day Year
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T at a	2 CV	Completed					·· ++	24a. Was an autopsy performe	ed/ death?	itopsy findings available completion of cause of
Vital F sicien: The	ector,	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only one)		
On Of Jing Phys	funeral di	tion: To	1 Yes 2 No  27. Manner of f ath 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		of 28c. I	Other: 4 Nursing	Home 5 Residen 28d. Describe how		city)
	completely filled in by the	27. Manner of Fath    Manner of Fath   M							et and Number or Ru State)	ıral Route Number,
To the Hospitel or within 24 hours after to the Funeral Director of the Funera	letely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medicel Exem	vsician: To the best of iner: On the basis of e and manner state	xamination and/or it	th occurred at the	e time, date and plac ny opinion, death occ	ee, and due to the cau curred at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
To th withir	comp	M	29b. Signature and titte of certifier	1/		29c. Lic	ense number	290	d. Date signed (Monti	h, Day, Year)
			Marson	atrun	m	1.7).	26650	9	7-04	
4	2		30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (Type	Print)	Lux.	Oak line	1. Ud a	レハラン
	Sta		31. Date (illed (Month, Day, Year)	32. Registrar	's Signature	0	Johnson	a my man	1 1000	-,,,,,
R	egistra	ar	SEP 7	2004	man M	Amonto.				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year September 07 1640 PM 2004 Sarah Albertha McElroy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1□M 2∏F Yrs. Director 219-20-0444 Feb.3, 1926 Maryland Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location item 27 ie marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Mcdical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death by Funeral 21740 USA 17725 Garden Spot Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene.

le marked other then "naturel", or itel Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No 3√Widowed 4 □ Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Mole Scott Zoe Ellen Mellott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: if Item 27 le n any injury or other treun <u>once.</u> 17725 Garden Spot Drive Hagerstown, Maryland 21740 of Disposition (Name of Date 20c. Location - City or Town, State Linda Shirley - Daughter
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Greenlawn Mem. Park Sept.10,2004 Williamsport, Maryland ture of Funeral Se OSborned Funser agiity Home, P.A. 425 S. Conococheague St.Williamsport, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** 119 disease or condition resulting in death) /Medical Due (o) (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 ☐ Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ♥ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and little 29c. License number 5H-2 person who complete cause of death (Item 23a) (Type, Print) East 32. Régistrar's Signature 31. Date filed /Mo State

DHMH 17 Rev 1/2001

Registrar

MILBURN

MARGARET

			1 - State of N	Maryland / Depa <i>Cer</i>	artment of I		Mental Hy	giene	04	29852										
	Physici		1. Decedent's Name (First, Middle, Last) Theodore Roosevelt Mc	:Neill			2. Date of De Sept	6, Day 004	Year	3. Time of Death 5:00 A.M										
	/Medio Examir		4a. Facility Name (If not institution, give street and number 4912 Vienna Drive		Clint		1	4c. Count	ty of Death											
	Funeral Director		5. Social Security Number 6. Sex 7. A 237 50 9265 XX M 2 F	ge (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec 2,	rth a <i>y, Year)</i> 1935	9. Birthi Cou Nort	place (State or Foreign intry) ch Carolina										
	Maryland	tor	10a. State 10b. County  Maryland Prince George's	10c. City, Town or Loc	nton	*		-		10d. Inside City Limits 1 ☐ Yes 2 XX										
	h with the 23a or 28s	al Director	10e. Street and Number 4912 Vienna Drive		10f. Zip Code	0735		10g. Citizen of	What Coul	intry?										
980	be filed within 72 hours after death with the Maryland Ital Hygiene. ad other than "natural", or Items 23a or 28a-1 ahow avant, the Medical Eval in at must be restilled at	by Funeral	11. Marital Status  1 □ Never Married 2 □ → 1 □ Vever Married 2 □ 1 □ Vever Married 1 □ Vever Married 1 □ Vever Vear or Dates:	No Vietnam 1	Vas Decedent of H	Hispanic Origin? (Si an, Mexican, Puert Specity:	pecify Yes or No o Rican, etc.)	5- 14. Ra Bla	ice - Americ ack, White,											
Maryland 21215-0036	e filed within 72 ho al Hygiene. other than "natur vant, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give k	ent's Usual Occup kind of work done OO NOT use retire CUtive C	during most of word d)	king	16b. Kind of E		ndustry										
yland 2	2 should be filed and Mental Hygid Is markad other sumatic avant, II	To Be C	17. Father's Name (First, Middle, Last) Charles Edward McNeill			18. Mother's Nam	Mae Ro	, Maiden Sumai berts	me)											
	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 Ia markad any Injury or othar traumatic a <u>ence.</u>		19a. Informant's Name/Relationship (Type, Print) Suk McNeill (Wife)	4912	Vienna	and Number or Run Drive, Cl	inton,	Marylan	d 20	735										
altimore,	it. Pages rtment of H rtant: If Ite		20a. Method of Disposition  1 □ Burial 2 □ Stremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  21. Signature of Fuesta Service Licensee	Lee Crema	tory Sep	t 7, 2004		20c. Location	n, Ma	ryland										
Ba	Dermi Depa Impo		Man MA	0100362 A	lexandri	ss of Facility Lee a Ferry R	d, Clin	ton, Ma		d 20735										
8	Physician /Medical		23a. Part1. Enter the disease, or comprigations that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  Due to (or as	s a consequence of):	villy	ming, such as cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death										
8760,	cate be executed by physician and the burial-transit and	lysician/Medical Examiner	dical Exa	dlcal	Physician/Medical Examiner	dical	dlcal	dlcal	dical Exa	sal Examiner	sal Examiner	resulting	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as Due to (or	s a consequence of):	AND	dise	in			5 W
.O. Box 6	The law requires that the death certificate tite has been signed by the attending phy bage 2 should be detached for use as the									IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome   1   Live birth   4   Pregnant a   9   Unknown   Unknown   24c.   25c. If yes, outcome   1   Live birth   4   Pregnant a   9   Unknown   25c.   2 Fetal death 3 E	Ectopic pregnancy Other (specify)	,			ite of delive	ory Day Year				
ords, P.	w requires that been signed k should be det	by	Part II. Other significant conditions contributing to death t	out not resulting in the und	derlying cause givi	en in Part I.		obacco use cont		ne cause of death?										
Vital Records,		Completed					24a. Was a autop perfor	med?	prior to con death?	psy findings available inpletion of cause of										
	Phyaician: Th this certificate al director, paç	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) No Hospital: 1 \( \text{Inpatial} \) Inpatial:	ent 2 ER/Outpatient	3□ DOA Othe	26. Place of Deat	me 5 Resid		er (Specity	()										
Division of	Jing After funer	Certification;	27. Mannar of Death 1 CNatural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be				28d. Describe h													
Ω	Hospital or Attand 24 hours after death Funaral Diractor: tely filled in by the		4 Homicide determined 206. Place of Infi	jury - At home, farm, streetc. (Specify)			28f. Location (S City or Tow	n, State)												
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	oxamination and/or my	occurred at the timestigation, in my op	oinion, death occurr	ed at the time, o	ause(s) and ma date and place, a 29d. Date signed	and due to	the cause(s)										
<b>(</b>	- 3 - 8		30. Name and address of person who completed cause of c	MD Atten	due -2	4535	, '	09,		, /										
	3)		Laxmi N. Berwa, M.D. 7700		•	te C-101,	Clinto	n, Mary	land	20735										
	Sta Registra		SEP 0 8 2004	ar a signature	not only															

			State of Maryland / Department of Health and Months    1- State			
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	. No.	3. Time of Death
	Physicia	an		Month	Day Year	au
	/Medic		Irene K. Moore  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	August 28	8, 2004 4c. County of Deatl	7:35 m
	Examin	er	Renaissance Gardens at Riderwood Village Silver Spring	7	Montgom	erv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry)
М	Director		217-24-2273 1 M 2K F 74 Yrs. Months Days Hours Min.	Sept. 20,	1929 New	Jersey '
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	anylai shov	<u>_</u>				1 ☐ Yes 2 🏋 No
	8e-f	ecto	Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip Code	100	. Citizen of What Co	
	a or	ă	10e. Street and Number 10f. Zip Code 20910	iog	USA	unity:
	eath	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spering Forces)  14. Was Decedent of Hispanic Origin? (Spering Forces)	cify Yes or No-	14. Race - Ame	
10	r Itan	Fun	1 Never Married 2 Married 1 Yes 2 No	Rican, etc.)	Black, White	
21215-0036	72 hours after death with the Maryland Inetural; or Itams 23a or 28e-f show Jisel Examiner must be notified at	by	3 ∑XWidowed 4 □ Divorced If Yes, Give Year or Dates:		Specify: Wh:	rce
5-0	72 hc netu	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working)	16l	b. Kind of Business/	Industry
21	nthin ne. han	idm	Elementary/Secondary (0-12) College (1-4or 5+) 5+ Music Teacher		D	
7	liled v lygie thar t nt, In		5+ Music Teacher  17. Father's Name (First, Middle, Last)  18. Mother's Name		Education	
anc	the fundal h	Be c	Frank C. Kopp Pearl I.			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 27 Ia marked other than "netural", or thams 23a or 28e-f show item 27 Ia marked other than "netural", or than atte or office at other traumatic avent, I'm Medical Examinar must be notified at	J.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural	l Route Number, C	City or Town, State, 2	ip Code)
Ma	th ar 1th ar 27 la r trau		Thomas D. Moore/ Son 8400 Hartford Avenue.	Silver S	nrang MD	20010
ē,	f Hea f Hea itam		20a Method of Disposition 20b. Place of Disposition (Name of		c. Location - City or	
e E	Page: ent o nt: If		1 Burnal 2 Externation 3 Hemova from State Metropolitan 200		exandria,	Virginia
Baltimore,	permit. Pages 1 and 2 shou Department of Health and M Important: If itam 27 Ia mat eny injury or other traumat		21. Signature of Fyneral Service Licensee  22. Right and Address of Facility in Francis 1. Collins	Funeral	Home Inc.	
Ö	Depar Impor eny ir	10	Solver Solversity Blvd,	W, Silv	er Spring	, MD 20901
	. 4		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	r respiratory arrest	•	Approximate Interval Between
	Pnysician	6	Immediate Cause (Final disease or condition a Advanced Alzheimer's Disease			Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):			
В	Examiner		Sequentially list conditions, if any, leading to immediate  b. Parkinson's Disease  Due to (or as a consequence of):			
	ed isit	Examiner	if any, leading to immediate  Cause, Enter Underlying  Cause, (Disease or injury)			
	xecut and al-trar	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	licate be executed physician and s the burial-transit	alE				
687	tificate ig phy as the	edical	V			
Box	di di	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of deli	,
	Ď o D	icia	in the past 12 months?  1  Yes 2 No  9 Unknown		Month	Day Year
P.0	that the de led by the a detached t	hys	9 D Onknown			
	op op		Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to	
ord	w require been si should I	ted	Decubitus Ulcer	TU Yes	2010 3011	obabły 4 🔀 Jnknown
of Vital Records,	2 2	Completed by		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
E	ate pag	S		performer		2 No
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?  Hospital: Control of Death Con			
of	Phys this al dii	. To	1   Tes 3x No 1   Inpatient 2   EH/Outpatient 3   DOA 4 1x Nursing Hon	ne 5 🗆 Residenc 28d. Describe how		city)
u	ding h. After funer	tion	27. Manner of Death  12 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  M 1 Yes 2 No		,,	
Division	Attanding r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 2	28f. Location (Street	et and Number or Ru	ral Route Number,
ρi	after after Dire	Certification;	4 Homicide building, etc. (Specify)	City or Town, S	state)	
	Hospitel 14 hours : Funaral tely filled		29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the caus	se(s) and manner as	stated.
	To the Hospitel or Attanwithin 24 hours after deatl To the Funaral Director:	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.			
	To the within 2 To the complex	Σ	29b. Signature and title of certifier Pulhumana, MD 29c. License number D59524	29d.	. Date signed (Month	
			double jamenary, 15 B59524		August 31	., 2004
(39)	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	C '		
			Loveen J. Puthumana, M.d. 3110 Gracefield Road, Silve 31. Date filed (Month, Day, Year) 32. Paistrar's Signature	er Spring	J, MD 2090	)4
	St: Regist	ate rar	GED 0 1 2004			

Amend Item 5 per fh G835 9-30-04 tas FoAmend Item #5 State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 9/14/04 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 4'06M Robert Lynn HARTLE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2 F Months Days Hours Min. 66 Yrs. Director June 19,1938 Maryland 231a9 Readence 5605 edent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Madical Examinal must be inclined at 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9900 Sharpsburg Pike 21740 USA Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 GYes 2 □ No If Yes, Give Year or Dates: 1957–1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ঽExNo Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) inspector truck manf. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be s and Mental Mental John A. Hartle Margaret E. Kershner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 I Judith Hartle - wife 9900 Sharpsburg Pike, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Rose Hill Cemetery 9/13/04 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw One and Death Immediate Cause (Final EMOUNTS **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Be Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) signed by the al d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use combute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 Mo 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 2 No 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 2/4 No 1 ☐ Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funaral Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu **20**22043 00 5H-10x1 (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Mor State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

D04115

State Registrar

DHMH 17 Rev 1/2001

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touseh

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Robert Birschbach, MD

SEP 0 2 2004

31. Date filed (Month, Day, Year)

201 Russell Avenue Gaithersburg, MD 20877

		State of Maryland / Department of Health and 1- State Amend 17, perFH, FCHD, SL, 9/9/ **Qertificate of Death	R	ag. No. 0 0 4	29857
Physic		Decedent's Name (First, Middle, Last)     GEORGE HOWARD NUSBAUM	2. Date of Dea Month Septemb	per 5, 2004	3. Time of Death 9:32 P M
/Med Exami		Ab City Town and posting of Day		4c. County of Death	
	ä	Frederick Memorial Hospital Frederick  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs	8. Date of Birth	Frederic	ς place (State or Foreign
Funera Director		215-18-1402 15 M 2 F 81 Yrs. Months Days Hours Min		, 1923 Mary	place (State or Foreign intry) yland
pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	-4		10d. Inside City Limits
Maryla f sho	ō				1 Yes 2 No
h the l	Directo	10e. Street and Number 10f. Zip Code	1	log. Citizen of What Cou	intry?
23a c	raiD	1001 Heather Ridge Dr./ Unit F 21702		United Stat	
within 72 hours after death with the Maryland iene "natural", or itams 23a or 28a-f show the Marical Eraminer must be notified at	y Funeral		Specify Yes or No- to Rican, etc.)	C/4-	, etc.
ithin 72 hours after name of the second seco	ed by	3 Nationed 4 □ Divorced Year or Dates: 1943-45   15. Decedent's Education   16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	ite
within 72 lene. than "nat	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	orking		·
filed wi th Hygien other th			me (First, Middle,	Floral	
a d a b a	To Be	Sr.			cant
2 should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R	lural Route Number	r, City or Town, State, Zi	p Code)
	1 8	Margaret Gladhill / Daughter 9580 Woodland Dr./ W	-		State
n 00		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location - City or T	
DCILLITIES  permit. Pag Department important: f any injury o		'4 Donation 5 Other (Specify) Resthaven Mem. Gardens 09/0 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility S			
Definit. Departing imports any injury.	1: 1	Raymond Belerson 1621 Opossumtown P			21702
Priysician /Medica Examinei		23a. Part1. Forer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	2		Approximate Interval Between Onset and Death
of ou, cate be executed by sician and the burial-transit	icai Examiner				
ath certifications or use as	Physician/Medi			23d. Date of deliv Month	rery Day Year
tus, F.C. I quires that the de n signed by the a	by	Part II. Other significant conditions contributing to death but not resulting in the uncertying cause given in Part I.		bacco use contribute to les 2 □ No 3 □ Pro	the cause of death?
VICAL NECOLUS, sician: The law requires I certificete has been signe rector, page 2 should be	Completed		24a. Was a autops perform	sy prior to co	opsy findings available ompletion of cause of
Cian: cian: ertifice actor, p	Be	25. Was case referred to medical 26. Place of De	ath (Check only on	10)	
on or vital he ling Physician: The la la ling Physician: The la After this certificete has tuneral director, page 2	ion: To			ence 6 Other (Speci ow injury occurred	fy)
To the Hospital or Attending Physicien: To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Re City or Town, State)		al Route Number,
ha Hospita n 24 hours na Funarai	edical C		e, and due to the ca urred at the time, d	ause(s) and manner as s ate and place, and due t	stated. o the cause(s)
To tha within 2 To tha complet	M	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month,	Day, Year)
		D21648		7/7/04	
6+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	eet F	Sciele 1	1321701
S Regis	tate trar	31. Date filed (Month, Day, Year) 0 7 2004 Server & Aparks)	7	-bide !	

			Registrar per info	, 9/9/049 M	, al Ce	rtificate of	Death		Reg. No.	04	29858	
п	Physici	an	Decedent's Name (First, Middle,	Last)				2. Date of D Month	eath Day	Year	3. Time of Death	
	/Medi	cal	Marjorie Barre  4a. Fecility Name (If not institution,			4h Cit. Taur	or Location of De	Augus		2004	12:54 P M	
	Examir	ıer						ath		nty of Death		
	Funeral		Holy Cross Hos  5. Social Security Number	•	je (In yrs. last birthday,		r Spring		rth	Iontgo 9. Birth		
	Director		103-20-2788	1□M 2 <b>X</b> F	81 Yrs.	Months Days	Hours Mi	n. ( <i>Month</i> , <i>D</i>	ay, Year) 2, 1923	Nev	place (State or Foreigr intry) V York	
	p ,		Usual Residence of Decedent  10a. State 10b. County		T40-0: +							
	show	5	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits 1 ☐ Yes 2 No	
	the N	Director	DC Non  10e. Street and Number	e	Washing	ton 10f. Zip Code			10g. Citizen	-6.14/5 - 1.0		
	with Ba or			Street NE		2001	7		US		intry?	
	ter death itams 2:	Funeral	1504 Lawrence	12. Was Decedent	Ever in U.S. 13.			(Specify Yes or N		Race - Ameri	can Indian.	
9	or ital	Ξ	1 Never Married 2 Marrie		No			(Specify Yes or Nerto Rican, etc.)		Black, White	etc.	
93	rai', o	d by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Spe	cify: Bla	ck	
21215-0036	within 72 hours after death with the Maryland ane. than "natural; or items 23a or 28a-f show to W. dical Ex., niner roust be notified at	Completed	15. Decedent' (Specify only highest	Education grade completed)	(Give	dent's Usual Occu	during most of w	orking		Business/Ir	,	
121	within ane. than	m m	Elementary/Secondary (0-12)	College (1-4or : 5+	5+)	DO NOT use retir	/	aniet	Washin Public	_		
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ary	s 1 and 2 should if Health and Men item 27 is marka other treumatic	-	19a. Informant's Name/Relationsh	p (Type, Print)	19b. Maili	ng Address (Stree	t and Number or I	Rural Route Numb	er, City or Tox	vn, State, Zij	o Code)	
	7.2 mg		Barbara J. Omoh	undro/ Daugi	hter 7610	16th St	., NW, W	ashington	n, DC 2	0012		
ore			20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 DRomoval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla		Date gust 31	20c. Locatio		own, State	
Ĕ	Pages ment of I ent: if its ury or o		'4 □ Donation 5 □ Other (Sp		Metropol: Cremato			2004	Alexan	dria	Virginia	
Baltimore,	permit. Page Department of Importent: if any injury or once.		21. Signature of Funeral Service L	censee				s Funera	l Home	Inc.	g, MD 2090	
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687	ficate p phys is the	edicai		d								
Box	death certificate be executed e attending physician and id for use as the burial-transit	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. [	Date of delive	erv	
•	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		]Ectopic pregnanc ] Other <i>(specify)</i> _			I	Month	Day Year	
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S,	res tha	by	Part II. Other significant condition								he cause of death?	
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3ec	e taw has b	Completed	Atrial Fibrilla	tion with P	acemaker			24a. Was auto	osy	prior to co	psy findings available mpletion of cause of	
al								1 ☐ Yes	rmed? 2 XNo	death?	2 No	
Ξ	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		Ot		eath (Check only o				
of		I – I	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju (Month, Da		nt 3□ DOA 28c. Inju	4 ∐ Nursing	Home 5 ☐ Resi			(y)	
ion	Attending I r death. ector: After by the funer	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investige		<i>Y Year)</i> Injury		irk? ]Yes 2 ∐No		. ,			
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Ö	0 = 0 =	Cer		building, ex	c. (Opechy)			City of 70	WII, State)			
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	To the within 2 To the comple	Me	29b. Signature and title of certifier	0 -		29c. Licen			29d. Date sign	ned (Month,	Day, Year)	
			> Kamai	1 K- (C	lo"	DIC	1609		Augu	st 29	, 2004	
900			30. Name and address of person we Raman Tuli, M.		eath (Item 23a) (Type. arnestown		02, Gaith	nersburg	MD 20	878		
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 1	32. egistra	ar's Signature	4	-, -3201					
	negisti	ar	SEP UI	200.	- N. A.	AND THE REAL PROPERTY.						

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DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day **Physician** earson-Bullis September 2 eanne-2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ltopkins ohns Hospital Itimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months 10 M 20 F Yrs. CONNECTICUT 573-38-8555 1, 1929 FEB. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State or 28a-f show 1 ☐ Yes 2 No Director QUEEN ANNE'S CHESTER MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21619 232 BENTON PLEASURE ROAD 238 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No filed within 72 hours after 1 ☐ Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 2 HOMEMAKER 12 other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event <u>once</u>. Be ROSE CRESENTE PERSEY ALBERT MINER ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 232 BENTON PLEASURE ROAD, CHESTER, MD 21619 WILLIAM P. BULLIS/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 09/04/2004 STEVENSVILLE, MD 22. Name and Address of Facility 21. Signature of Fyneral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat 30 Mins. rulmonary Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month ö in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autonsy 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1 X Yes 2 □ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 6 ☐ Other (Specify) P 5 ☐ Residence 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Iniury 5 Pending 1 Natural Clamp tore artery 1205 investigation September 2, 2004 death 2. Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 600 Wolfe St 3 Suicide 4 T Homicide fo the within 24 hours the Funeral Directory Johns Hopkins Hospital Baltimore, Md. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certifie pleted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Name and address

31. Date filed (Month, Day, Y) ar)

SEP 0 7 2004

Osler 624 32. Registrar's Signature 600 North Wolfe Street, Baltimore

Gerri Powell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-05688 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department / RJ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** Gerri Jondina Powell September 2004 10:49 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death Examiner 4c. County of Death Garrett County Memorial Hospital Oakland Garrett County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 200 F Director 219-70-9899 Sept 16, 1957 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at 1 XYes 2 No Director MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21550 125 Water St. USA Items 23a Completed by Funeral filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No ō Maryland 21215-0036 1 ☐ Yes 2 No Specify: white If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "natural" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) 12 th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked of Pages 1 and 2 should be John Miles Hester Haywood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Water St., Oakland, MD 21550 19a. Informant's Name/Relationship (Type, Print) Jimmie M. Casteel/husband t of Health othar t Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or once. Country Side Crem. Sept 3, 2004 Davidsville, PA \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Pervice Licensee Newmand funeral Homes, P.A., PO Box 275 179 Miller\_St., Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) **Physician** Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Woknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 2 Yes 2 □ No of Vital 1 Yes 2 🗆 No or Attending Physiclan: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2/2 ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a Illad 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME September 3, 2004 (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death THEODORE Mile 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State 0 2004 Registrar

			1- State of Maryland / Dep Registrer Ce	artment of Health and Nertificate of Death		g. No. UU4 29862
	Physici	22	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	/Medic		Arthur M. Perry	T	August	31,2004 11:28 AM
7	Examin	er	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital	4b. City, Town, or Location of Death  Lanham		4c. County of Death Prince George
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	·
	Funeral Director		242-70-4353 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Months Days Hours Min.	(Month, Day, 1 April 11	
			Usual Residence of Decedent		<u> </u>	
	anylar ehow	_	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 X Yes 2 ☐ No
	88-f	ecto		Heights	10.	g. Citizen of What Country?
	with the	Funeral Director	10e. Street and Number	10f. Zip Code 20743	10	USA
	ns 23	era	7409 Shady Glen Terrace  11. Marital Status 12. Was Decedent Ever in U.S. 13.		ecify Yes or No-	14. Race - American Indian,
(0	ours after death with the Marylan ral', or tems 23e or 28e-f ehow Examiner must be notified at	표	1 Never Married 2 Married 1 Yes 2 No If Yes, Give		Rican, etc.)	Black, White, etc.
215-0036	72 hours after death with the Maryland natural', or Items 23e or 28e-f ehow Jisel Exantret mutte natified at	d by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: Black
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121	filed within Hygiene. other then "	duo	Elementary/Secondary (0-12) College (1-4or 5+)	nter		Washington Post
d 21	be filed within 72 hatal Hygiene. d other then "naturesont, Ire Madical		17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	
<u>a</u>	should be filed within and Mental Hygiene. marked other then metic event, the Mental and the Men	To Be	Ellis Perry, Sr.	Ella Pe	erry	
Maryland	S should be filed with and Mental Hygiene. Is marked other the sumatic event, the			ing Address (Street and Number or Run		
	Health a tem 27 is other train			Baywood Forest Dr		
Baltimore,	to to			matory or other place)		Oc. Location - City or Town, State
Ë	Department Department mportant: I any Injury c			1 Cemetery 9/5/ 2. Name and Address of Facility Str		Colerain, N. Carolina
Bal	Depar Depar Impor any tr			500 Allentown Rd,		
			23a. Patt . Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter III mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death
5	Priysician		Immediate Cause (Final disease or condition resulting in death)	neumon	ca	
1	/Medical Examiner		Due to (or as a consequence of:	su velous	Amo	s t
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o,	death certificate be executed to attending physicien and by for use as the burial-transit	Exa	resulting in death) Last  Due to (or at a consequence of):	2 1/20	10	1000
9760	ate be hysici ihe bu	lical	d. Hyperte	nsive Hear	14 11	SLASE
39 x	ertifica ding pt	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	<del></del>		004 0-1445
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rds	w requires been sign should be	ed b	Hype Lipidemia		1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	ie law requ has been ge 2 shoult	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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<u>S</u>	s after s after or all Director	Certification;	4 Homicide determined building, etc. (Specify)		City or Town,	State)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	To th withir To th	Me	29b. Signature and the of certifier	29c. (Thense number 2 9.2 (	05	d. Date signed (Month, Day, Year)
	@ DEH	1	30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Greenbelt	MD.	20770
	-		31. Date filed (Month, Day, Year)   2. Registrar's Signature	)	/ 1 4	, , -
	Sta Regist		SEP 0 7 2004 Keen & Spe	W		

		-	For State Registrar	State of Maryla		artment rtificate				jiene		20263
		_	Decedent's Name (First, Middle, Last	1)					2. Date of Dea Month		Yeer	3. Time of Death
	Physicia /Medic		Christopher Cline	e Pickett					Septem	per 2,	2004	10:30 p <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give					ation of Dea	th	4c. County		
			5809 Cherrywood				reenb	elt Under 24 Hrs	Do Date of Birds			orge's
	Funeral		5. Social Security Number 6. Security Number 16. 7. Age (in yr M 2□F 49	s. last birthday) Yrs.			ours Min	. (Month, Day	, Year)	9. Birting Cour	lace (State or Foreign ltry) .ngton, DC	
	Director	-	Usual Residence of Decedent			l			pec. 30	, 1904	wasiii	ington, bo
	yland 10W		10a. State 10b. County	10c. 6	City, Town or Lo	ocation					1	Od. Inside City Limits
	a-fal	ctor	Maryland Prince G	eorge's	Greenbe	elt						1 X Yes 2 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip (				I0g. Citizen of \	Vhat Cour	ntry?
	ath w	rai	5809 Cherrywood		11.0		0770		Consider Van or No	U.S.A.	o - Amorio	an Indian,
	er de Items	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	0.5.	If Yes, speci	fy Cuban, M	lexican, Pue	Specify Yes or No- no Rican, etc.)		k, White,	
36	irs aft		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No S	oecify:		Specify	" Whi	te
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or ltems 23a or 28a-f show the Madical Exerciber must be notified at	Completed by	15. Decedent's Ed	ucation		dent's Usual			orkina	16b. Kind of B	usiness/In	dustry
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п	be fill H d off	Be	17. Father's Name (First, Middle, Last) Phil Pickett						Marvus (			
2	d Mer narke	ဥ	19a. Informant's Name/Relationship (7	Type Print)	19h Maili	na Address			Rural Route Numbe			Code)
Maryland	d 2 sl th an t7 ls r traur	l i	Sharon Lee Picke		1				#204, G			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be notified at ance.		20a. Method of Disposition		. Place of Dispo cemetery, cre			Lane,	Date	20c. Location -		
Baltimore,	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State				y 9/	7/2004	Alexand	ria,	Virginia
a E	mit. partm partm porta / inju		21. Signature of Funeral Service Licen	see	2	2. Name and	Address of	Facility Ga	sch's Fu	neral H	ome,	P.A.
Ö	Depa Depa Impo any ii		23a. Part1. Enter the disease, or comp	and Lanni					., Hyatt		MD 2	20781
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.O. Box 68	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pred 1 Live birth 2 For 4 Pregnant at time of 9 Unknown	etal death 3	⊒Ectopic pre ⊒ Other (spe				23d. Da Mo	te of delive	ery Day Year
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sio	Attending or death.  Ractor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		thoma form of	M		2 □ No	28f Location (9	treet and Numb	er or Rus	Il Route Number,
Division		Certification	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)	reer, ractory,	, onice		City or Tow	n, State)	0, 0, 1,0,0	Troute Hamber,
lund	Hospite 4 hours Funeral ely fille	edical C		ysician: To the best of my land manner stated.								
	To the within 2.	Me	29b. Signature and little of gentilier	- //			License nu			29d. Date signe	d (Month,	Day, Year)
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Ċ	R		30. Name and address of person who John S. Pulizzi,	/			l, Sui	te 1,	Alexandr	ia, Vir	ginia	22302
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 7 2004	. Registrar's Si	gnature of	the same						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 30, 2:00 a Victoria M. Poorman August 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6702 Newport Road Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 73 Yrs. 226-38-0354 1930 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 6702 Newport Road 20784 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Short Order Cook/ Waitress Restaurant Pages 1 and 2 should be filed v thent of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic evant. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marion Arthur Cynthia Louranie Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leona Pearl Crabtree - Sister 6700 Newport Road, Hyattsville, Maryland 20784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ Burial 2 
☐ Cremation 3 
☐ Removal from State permit. Page Department Important: It any injury o \* 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 9/2/2004 Suitland, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue, Hyattsville, MD 20781 Sauch danning 23a. Part1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Rectal Cancer, Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and the burial-transit the Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): O. Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached f 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Hypercholesterolemia, Osteopetrosis, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Rheumatoid Arthritis, Basal Cell Carcinoma 24a. Was an autopsy performed? 1 ☐ Yes 2<u>X</u> No Division of Vital 26. Place of Death (Check only one) Certification: To Be 25. Was case referred to medical examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending death, 1 Yes 2 No investigation 2 ☐ Accident within 24 hours after deat To the Funeral Diractor: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane, Upper Marlboro, Maryland 20774-5374 Adrian Hurley, 31. Date filed (Month, Day, Year) State SEP 0 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 3, 2004 **Physician** 6:43 Millard Pope /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
August 22,1923 North Carolina 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 X M 2 □ F 246-24-0699 81 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show ?? ie marked other than "natural", or items 23a or 28a-f sho traumatic event, it e Medical Examiner must be notilied al 1X Yes 2 □ No Director Centennial Colorado | Arapahoe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 80122 Phillips Place 2037 E. Pages 1 and 2 should be filed within 72 hours after death went of Heelih and Mental Hygiene. ant: If item 27 ie marked other than "natural", or items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕅 No Specify: Specify: 3 1x Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Bus Driver Transportation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fannie Roberts William M. Pope 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Heelth item 27 i 2037 E. Phillips Place Centennial, Colorado 80122 Don Pope / Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Importent; if ite any injury or of once. 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Coats Cemetery 09/08/04 Coats, North Carolina 22. Name and Address of Facility Stauffer Funeral Homes, P.A. vice Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit 9 Due to (or \* a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE ME If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year for Day 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 28e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 90 1 ☐ Yes 2 🗷 Ño 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1(4) MAIN Yes Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred □Natural 5 Pending 3,2004 10:00 A M 1 Tyes investigation Accident 24 hours after death Funerel Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 | Homicide filled in Assisted 7400 willow Rd Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 D16428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ÍÒ Frederick, Maryland 21701 Casper E. Cline, M.D. 300 W. Ninth Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar South 2004

		•	For State	State of	Maryland	-	artment <i>tificate</i>			and Me		giene	00:	<b>~</b>	0000	
			1. Decedent's Name (First, Middle, Last)							2	2. Date of Dea	ath			Time of Death	-
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	/Medic Examin		4a. Facility Name (If not institution, give s	treet and nun	nber)		4b. City, 1	l'own, or	Location o	f Death		4c. C	County of De	ath		
		Н	2610 Urbana Pike						svill				Frede			
П	Funeral		5. Social Security Number 6. Sex	M 2□F	7. Age (In yrs. la		If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da)	h v, Year)			(State or Foreign	
ш	Director		219-03-4153	141 201	84	Yrs.				N	ov. 6,	191	9   M	lary1	and	_
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	ith the Marytan or 28a-f show	Directo	10e. Street and Number		1 1 4 1		10f. Zip	Code				10g. Citiz	en of What C	Country?		
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	ams arms	Funeral		12. Was Dece Armed For	dent Ever in U.:	S. 13.	Was Deceded	ent of Hi	spanic Orig	gin? (Spec , Puerto Ri	fy Yes or No- can, etc.)	. 1.	<ol> <li>Race - Arr Black, Wh</li> </ol>		dian,	
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Ś	oud be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. Refact other than "natural", or Itams 23a or 28a-f show attic event, the MacKeal Examiner must be natified at		15. Decedent's Educ		ates: WWII	16a Dece	dent's Usua	I Occupa	ation		1	16b. Kin	d of Busines	Whit		_
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2	should be filed within to Mental Hygiene. markad other than matic event, the M.	ø	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (	First, Middle,	Maiden S	Surname)	_		
2	Alenta Alenta rkad tic ev	lo B	Martin Luther Pool	Le					Leo1	a Sav	age					
20	g p E E	•	19a. Informant's Name/Relationship (Type	oe, <i>Print)</i>		19b. Mailir	ng Address	(Street a	and Numbe	r or Rural i	Route Numbe	er, City or	Town, State,	Zip Code	e)	
<u>.</u> .	s 1 and 2 should f Health and Men Item 27 is marka other traumatic		Virginia A. Poole	Wife W	1001 51				ike,	Ijams Da	ville,					_
ב כ	of H		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from	0.0	lace of Dispo emetery, crer	sition (Nam natory or ot	ne or Ther place					ation - City o			
	Pag tment tent: jury o		`4 ☐ Donation 5 ☐ Other (Specify)		Mt.	Oliv				/9/20	004	Fred	erick,	, Mar	yland	_
Dallillor	permit. Pages 1 and 2 Department of Health a Importent: if Item 27 it any injury or other tra ance.		21. Signature of Edneral Service License	1 km	, /	ΙΩ.	Name and	Mo.	LESTIO	rth P	. A. F	uner	al Hom	e 200	72	
	40200		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that c	aused the death	. Do not ent	er the mode	of dving	z. such as	cardiac or	respiratory ar	rest.	гутапо	Арр	roximate	-
	. , .		shock, or heart failure. List only or Immediate Cause (Final	~	- 1										rval Between et and Death	
P.	Physician /Medical		disease or condition resulting in death)		or as a consequ		NCE	R						,	1R	_
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	ding F h. After funer	ion:	27. Manner of Death 1 ②Natural 5 ☐ Pending 3 ☐ Accident investigation	(Mont	th, Day Year)	Injury	M	8c. Injury Work	k? Yes 2∐I							
VISION	uttend death ctor: y the	ertificati	3 ☐ Suicide 6 ☐ Could not be	28e. Place	of Injury - At ho	me, farm, sti					f. Location (S		Number or F	Rural Rou	ite Number,	_
≥	after Dire	erti	4 Homicide	buildi	ng, etc."( <i>Specif</i> y	1)					City or Tox	vn, State)				
	To the Hospital or Attending Pl within 24 hours after death. To the Funerel Director: After completely filled in by the funera	Saic	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exami	sician: To the	best of my know	wledge, deat	n occurred a	at the tim	ne, date an	d place, an	d due to the	cause(s) a	and manner a	as stated.	cause(s)	
	the Ho in 24 the Fu	Medical	one)	and mani	ner stated.											_
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-	otl		30. Name and address of person who co			23a) (Type,	Print)	8 Hors.	Jon!	De.	FREE	ERIC	ck n	~0 2	21702	
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	Physic /Medi		1. Decedent's Name (First, Mic Ethel L. Robin	nson							2. Date of Do Month Sept.	D	ay 2004	Year	3. Time of Death
	Exami	ner	4a. Facility Name (If not institu Garrett County	y Memorial	Hospita		Oakl	and	Location of			4	c. County of		
	Funeral Director		5. Social Security Number 234–26–6350	6. Sex 1 □ M 2 🛣 F	7. Age (In yrs. 88	last birthday). Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bi	th Year	7015	Count	ace (State or Foreign ry) Virginia
	aryland show	2	Usual Residence of Decedent  10a. State 10b. Cour  WV Tucke	•		ty, Town or Lo	cation							10	d. Inside City Limits
	with the M a or 28e-f Le notifie	Directo	10e. Street and Number HC 60, Box 90				10f. Zip	<sup>Code</sup> 2629	12			10g. C	itizen of Wh		1 ☐ Yes 2 🔀 No
336	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28e-f show any injury or other treumatic event, tre Madical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ M 3 ፟ Widowed 4 □ Divorce	arried 1 ☐ Yes	2 <b>X</b> No	i		ent of His Ify Cubar		gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	)-	14. Race -	America White, e	
21215-0036	d within 72 hou giene. ir than "neture It e Madical E	ompleted	15. Deced (Specify only high Elementary/Secondary (0-12	ent's Education hest grade completed)		16a. Deced (Give life. L	OO NOT us	l Occupa k done di e retired)	tion uring most	of worki	ng	U.8	Kind of Busin	ernn	ent
Maryland ;	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle Wayne K. Lough	-,,							(First, Middle, O. Mor	Maide		011	.106
	and 2 sho alth and 27 is mu er treum		19a. Informant's Name/Relatio Margaret Ann F		ter	19b. Mailin	g Address Walnu	(Street ar	nd Numbei	r or Rura Colu	Route Number	er, City MD	or Town, St. 21044		Code)
Baltimore,	Pages 1 ament of He ant: If itam ury or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 1 □ Donation 5 □ Other			Place of Disposemetery, crem SONS Ci	atory or off	her olace			, 2004		ocation - Cit	•	n, State
l Balt	permit. Departimonal import any inj		21. Signature of Funeral Service	Juna		1	79 Mi	ller	Star	Gra	es, P.A	le.			
	certificate be executed  XX  We ding physician and indicate as the burial-transit  The partition of the part	dical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a co	uence of):	LIMBY		, such as c	ardiac or	respiratory ar	rest,		1	Approximate niterval Batween Driset and Death
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on or	ding Phys n. After this funeral di	ertification: To Be	examiner?  1 Yes 2 No  27. Manner of Death    Notural 5 Pend 2 Accident inves	Hospital: 1 X In  28a. D te of (Month)		ER/Outpatient 28b. Time of Injury		Other: c. Injury a Work?	4 🗆 Nurs	ing Hom 28	(Check only or e 5  Reside 3d. Describe he	ence (	6 □Other (5 y occurred	Specify)	
Ë D	To the Hospitel or Attenomitin 24 hours after deatl To the Funarel Director: completely filled in by the	O	4 Difficilities	mined 288. Place of building	f Injury - At hor g, etc. <i>(Specify)</i>						f. Location (S. City or Town	n, State,	)		
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			For State Registrar	State of Maryland		rtment of H			ene 3. No.2 () () 4	29868
2	Physicia		1. Decedent's Name (First, Middle, Last) Warren Ediso	n Reed				2. Date of Death Month Sept. 8	Day Year 2004	3. Time of Death 10:00а м
<b>1</b>	/Medic Examin		4a. Facility Name (If not institution, give s 12652 Pecktonv			4b. City, Town, or Big P	Location of Death		4c. County of Dea Washin	
	Funeral Director		5. Social Security Number 6. Sex 219-12-0061	7. Age (In yrs. Ias. 81	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y NOV . 12	(ear) 9. Bir (1922	thplace (State or Foreign buntry) Maryland
	aryland show dat	_	Usual Residence of Decedent  10a. State 10b. County  MD Washing		Fown or Loc					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	vith the M or 28a-f be notifie	Director	10e. Street and Number 12652 Pecktonv			10f. Zip Code	711	100	g. Citizen of What Co	
350	hours after death with the Maryland tural; or Itams 23a or 28a-f show al Exaciliner must be molified at	by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 _ Yes _ 2 \tilde{N} No If Yes, Give Year or Dates:			ispanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9500-61212	e fited within 72 hou al Hygiene. other than "natura vent, It e Me Jick I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th grade		(Give I	ent's Usual Occupa kind of work done of OO NOT use retired gineer	ation during most of work )		Sb. Kind of Business Air Craf	
land	uld be fited fental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Daniel Elwood	Reed				e (First, Middle, Ma Margaret		
Mary	alth and N		19a. Informant's Name/Relationship (Type Freida Reed s	pouse	1265	2 Peckt	onville		City or Town, State, .	Zip Code) MD 21711
Baitimore,	Pages 1 ar		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R:  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Par	e of Dispos letery, crem khea	sition (Name of latory or other place d Cemete	Sept.11	,	oc. Location - City or Big Pool	
Вап	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service License	14 -17	D D	Name and Address	dwin The	ompson F	uneral H	Home, Inc
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	RECTAL I	HIE,	4	g, such as cardiac		1.	Approximate Interval Between Onset and Death
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific cumpletely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir one)	sician: To the best of my knowled her: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau red at the time, date	se(s) and manner as e and place, and due	s stated.  to the cause(s)
)	Tott Tott	Σ	29b. Signature and title of certifier	itis Wag	SP	29c. License	1 2 2043	290	Date signed (Mont	h, Day, Year) )4
1	4.10		30. Name and address of person who of	mpleted cause of death (Item 2	3a) (Type, 1	Cal Camp	us Va	Hogerst	own Mi	21742
	Sta Regist		31. Date filed (Month Par Year) 2	32. Registrar's Signatur	· A	and s		0		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 6:38P<sup>M</sup> Francis Vernon Ridgell 2, September 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 47605 Beachville Road St. Inigoes St. Mary's If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Director 1931 213-36-3410 73 May 6, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frams 23e or 28e-f show the Medical Exemple: must be notified at 1 ☐ Yes 2X No Director St. Mary's St. Inigoes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 47605 Beachville Road 20684 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2XXVo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Ridgell 2 Viola Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 177 St. Inigoes, Maryland 20684 Randy Wimberly (Personal Rep.) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept.8,2004 20c. Location - City or Town, State 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 5 Other (Specify) <sup>¹</sup> 4 □ Donation Michaels Cath. Ch. Cem. Ridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear-/Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Unknown been signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 N 3 □ Probably 4 □Unknown 1 Tyes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of 29d. Date signed (Month. Day, Year) nu 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen SIMary David Loonard town 31. Date filed (Month, Day, Year) SEP 0 32. Registrar's Signature State 7 2004 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mildred Elizabeth Rund 2004 August 30, 10:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 □ XTE Yrs. Director 220-05-7444 84 25, 1920 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits iem 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 West McKinsey Road Apt. # 134 death Completed by Funeral 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. illed within 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Financial Statistician Western Electric 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nd Mental I Frederick Daniel Caspare ٩ Lillian Anna Schlabecker 19a. Informant's Name/Relationship (Type, Print) Friend and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 I Rev. John David van Dooren/ 2300 Cathedral Ave. N.W. Washington, D.C. 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 3, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important; If ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy. Severna Park, MD 21146 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** EN.D STAGE DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Due to (or as a consequence of): physician Be Completed by Physician/Medical the as attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 No 9 ☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an 1 Yes 2 No 1 Yes 2 No or Attending Physician: : After this certification of tuneral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence (Specify) 45555750 Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide ni bellii within 24 hours at To the Funeral E completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai and manner stated. 29b. Signature and title of certifier money 057531 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 860, veterar May mellersville mp 21108 32. egistrar's Signature State Registrar

Baltimore, Maryland 21215-0036

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			1 - For State Registrar	State of Marylan		rtificate of I			200	1. 20071
	7		Hegistrar     Decedent's Name (First, Middle, Last	)		tinicate of t	Dealii	2. Date of Death	g. Nó.	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	August	29 20 4c. County of	
			Southern Maryla	and Hosnital		Clinto	n		Prince	e George's
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. i		Months Days	1f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		499-34-0152 Usual Residence of Decedent	68	Yrs.		1	1ay 16		Missouri
	tand tand		10a. State 10b. County	10c. City	, Town or Lo	ecation				10d. Inside City Limits
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	r 28e	Director	10e. Street and Number	dedige B	opper	10f. Zip Code	10	10	g. Citizen of Wh	at Country?
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	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.		ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc.
36	hours after death with the Maryland turel', or Items 23a or 28e-f show al Examinet must be notified at	by Fu	1 ☐ Never Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2X☐ No			Specify:	Black
8	d within 72 hours after death with the Marylan Jishe. r then "naturel", or Items 23a or 28e-1 show the Medical Examinet must be notified at	edt	15. Decedent's Edu	Year or Dates:	16a, Dece	dent's Usual Occupa	ation		6b. Kind of Busin	ness/Industry
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212	d with giene er the	Completed	12th	0	Gran Spec	ts Mana ialist	gement	]	Educati	ion
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yla		ဥ	Etchey Wood					Wolmacl		
Maryland 21215-0036	2 8 8		19a. Informant's Name/Relationship (T)		19b. Mailin	ng Address (Street a	and Number or Rura	l Route Number,	City or Town, St	ate, Zip Code) 20772
d)	l an feal feal m 2		Oliver Randall 20a. Method of Disposition	(Husband)	1660	5 Villa	ge Drive	West L	Ipper N	Marlborn, Md ity or Town, State
آو	ages nt of h		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F	Mn A	ametery, crei	sition (Name of matory or other place	ran 9/7/			
Baltimore,	permit. Pages 'Department of H Importent: If Ite any Injury or ot		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>	Cem	etery	Name and Address	es of Eacility	100		nam, Marylan
Ba	Departing on Ir.		1 HR	- 44005600	W	m. Reese	e & Sons	Mortua	arv, P.	. A .
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the death	n. Do not ent	21 West er the mode of dyin	St. Ann g, such as cardiac o	abolis, respiratory arres	<del>, Md. 2</del>	21401 Approximate
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687	# × #			d						
×	eath certificat attending phy I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	псу				23d. Date of	of delivery
Вох	d for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	,
0	that the de led by the a detached f	hys	9 Unknown	9□ Unknown						
S,	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as it	by P	Part II. Other significant conditions con		ilting in the u	nderlying cause give	en in Part I.	23e. Did toba	icco use contribu	ute to the cause of death?
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	pspite hours inere y fille		29a. Certifier Certifying Phy	sicien: To the best of my know	wledge, death	occurred at the time	ie, date and place, a	nd due to the cau	ise(s) and manne	er as stated.
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	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	Σ	29b. Signature and title of gentifier	>	MD	29c. License		290	Date signed (A	Month, Day, Year)
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			30. Name and address of person who co	140			44	0 - 1	(1.1	110
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State of Maryland / Department of Health and Mental Hygiene

				State of Ivid	aiyiailu	•	tificate			•	Reg. No.	01.	000000
			1. Decedent's Name (First, Middle, Last)	1	-					2. Date of De	ath		3: Time of Death
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1	/Medic		4a. Fecility Name (If not institution, give	street and number)			· · · · · · · · · · · · · · · · · · ·		b. City, Town, or I			-	1107
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			5. Social Security Number 6. Sex		e (In yrs. las	st birthday)	If Under 1	1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthr	place (State or Foreign
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	∯ o €	급	10e. Street end Number				10f. Zip 0				10g. Citizen of	What Cour	itry?
	23a	ral	133 Louise Avenue					804			USA		
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, I'm Medical Exartical must be notified at once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🙀 N	Ever in U,S. No	İ			ispanic Origin? (S in, Mexican, Puert	pecify Yes or No o Rican, etc.)	Bla	ce - Americ ck, White,	
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sio	Attending or death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М		Yes 2 ☐ No	206 1	O4	-	(D + N
Division	or At efter of Direct	Certification:	4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home c. (Specify)	e, tarm, stre	et, factory,	office		City or Tov	Street and Numb vn, State)	oer or Hura	i Houte Number,
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier Certifying Phys	ician: To the best o	of my knowle	edge, death	occurred at	t the tim	ne, date and place	, and due to the	cause(s) and ma	anner as st	ated.
	n 24 n 24 ie Fu	edical	(Check only one) Medical Exemir	ner: On the basis of and manner sta	examination ated.	n and/or inve	estigation, i	n my op	oinion, death occu	rred at the time,	date and place,	and due to	tne cause(s)
	To th Within To th	ž	29b. Signature and little of certifier	11.0			29c.	License	number		29d. Date signe	d (Month,	Day, Year)
			OLDO.	NW)			•	1)	スムスー	78	8	30-1	<b>)</b> -{
			30. Name and address of person who co	mpleted cause of de	eath (Item 2	3a) (Type. F	Print)	<u> </u>	- 00	0	- 0	^	0600
0	Q		DAIDO COURLI	no	PO	R	x 17	32	Se	5/15/	, M	10	21802
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	(e //	1	1		(	)		
			ALIC 9 1 2	nna Na	merca	4	A	200 4	Val				

DHMH 16 Rev 6/95

			1 = For State Registrar	State of Marylar	-	artment tificate			and M		ene	29873
			1. Decedent's Name (First, Middle, Last)	-						2. Date of Death Month		3. Time of Death
	Physici /Medic		John Lawrence	Sulliv	an						Day Ye	04:00 PM
7	Examir		4a. Facility Name (If not institution, give s			4b. City, T	own, or	Location o	f Death		4c. County of D	
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		9116 Hummingbird (	Court		Hebr					Wicom	
	Funeral		5. Social Security Number 6. Sex	M OFF	last birthday)	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, June 14,	Year) g.	Birthplace (State or Foreign Country)
1	Director		218-52-8643 Usual Residence of Decedent	55	113.					June 14,	1949 Wa	shington, D. C.
	land ow		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	-f sh	ē	Marriand Winomine	u	ebron							1 Yes 2 No
	r 288	Director	Maryland Wicomico	1 116	EDLOIL	10f. Zip (	Code			10	g. Citizen of What	: Country?
	death with the Maryland		0116 Hamminghing (	Source		21	830				USA	
	deat	Funeral	9116 Hummingbird C	12. Was Decedent Ever in U Armed Forces?	l.S. 13. \			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Race - A	merican Indian, /hite, etc.
٥	ours after death with the Marylan ral', or items 23a or 28a-f show Examiner must be notified at	F	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 No		1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	, iloan, oto.,	Specify:	inte, etc.
5-0036	72 hours after "natural", or ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:								White
Ϋ́	72 an	Completed	15. Decedent's Educ (Specify only highest grade		(Give	tent's Usual kind of work DO NOT use	c done di	uring most	of worki	ng 1	6b. Kind of Busine	ess/Industry
7	filed within Hygiene. rther then "	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+)		mfitt					Constru	ction
ט ס	Hygi Hygi other	ပိ	17. Father's Name (First, Middle, Last)		SLec	1111L L L		18. Mother	r's Name	(First, Middle, M		CCIOII
an	id be ental ked c	To Be	Joseph Alovsi	us Sull	ivan			Els	io	Pheb	Δ S:	ampson
37	shou nd M mer	-	Joseph ALOVS 1  19a. Informant's Name/Relationship (Type	oe, Print)		g Address (	Street a				City or Town, State	
Ma	alth a		Theresa Ann Sulliv	van (wife)	9116 H	lummir	gbir	d Co	urt,	Hebron,	Maryland	d 21830
ore,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name	e of				0c. Location - City	
Ĕ			1   Burial 2  Cremation 3  R  1  Donation 5  Other (Specify)	emoval from State	-	-			oteni	xx 4,2004	Hebron,	Maryland
Ball	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licens	0.00	22	Name and	Address	s of Facility	al H	Ome Prof	essional	Association
n_	82789		1 lot 1 10 No	russey (FSP	1 :	OI Sn	OW H	HILL I	Road	, Salisb	ury, mar	ylana 21804
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat le caus son each line.	h. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ventre	rula	2	il	nel	las	102		Onset and Death
	/Medical Examiner		resulting in death)	Due to or as a conseq	uence of):	0	1	,		1		
	LAdminer	L	Sequentially list conditions, b	- Chem	uc	Ca	rd	ww	my ol	Thy		yrs
	be lisit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence oi):	: 6		_	1	-0		man -
	be executed sician and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a conseq	uence of):	- /K	aw	- 6	aus	esse		- Ju
)   	sician buria	calE										
200	death certificate e attending phys d for use as the		~~~	•								
žog	ieath certifi attending p I for use as	Z	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		N=					23d. Date of	delivery
	death e atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o		Ectopic pre Other (spe					Month	Day Year
j.	at the de by the a	hys	9 🗆 Unknown	9 Unknown								
s,	The law requires that ite has been signed b age 2 should be deta	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying car	use givei	n in Part I.				e to the cause of death?
cora	w requir been si should	ted	- Deaveres	mullus_						1 Tes	2 No 3	Probably Unknown
Φ	law r	old (								24a. Was an autopsy	prior t	autopsy findings available to completion of cause of
<u> </u>	(a) →	Completed								perform 1 Yes		i? 'es 2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			04			(Check only one		
0	Phys this al di	2	1 Yes 25 No	1 Inpatient 2 2 28a. Date of Injury	ER/Outpatien 28b. Time of			4 🗀 1401			ce 6 Other (S	pecify)
	ing After	tlon	Natural 5 Pending	(Month, Day Year)	Injury	M	c. Injury Work	at ? es 2 □ N		8d. Describe how	v injury occurred	
UIVISION	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, str				-	8f. Location (Stre	et and Number or	Rural Route Number.
$\leq$	F 6 F C	Certification:	4 Homicide	building, etc. (Specif	(y)	, , , , , , , , , , , , , , , , , , , ,				City or Town,		
	To the Hospital of within 24 hours af To the Funeral Completely filled in		29a. Certifier 1.X Certifying Phys	ician: To the best of my kno ner: On the basis of examina	wledge, death	occurred at	t the time	e, date and	d place, a	nd due to the car	ise(s) and manner	as stated.
	the H iin 24 the F iplets	ledical	une)	and manner stated.	ition and/or in				n occurre	od at the time, dat	e and place, and d	due to the cause(s)
1	Viit To	Σ	29b. Signature and title of certifier	/		,000		number	00	29	d. Date signed (Mo	onth, Day, Year)
•			Cloyland Co	al mo				192			7/2/	107
0	}	1	30. Name and indress of person who con	mpleted cause of death (Item	n 23a) (Type,	Print)	Div	11.00	50	Salist	May MID	21804
	Sta	te	31. Date fled (Month, Day, Year)	32. Registrar's Signa	ature /.	W/	NIV	, , , ,	001	over	any mis	0.001
6	Registi		SEP 0 2 200		B	100	aks	4				

			For State Registrar	State	of Marylar			of Health and of Death	l Mental Hy	giene Reg. No.	001.	20071
			1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath		3. Time of Death
	Physici		Arlene M.	Sol	domridge				Sep+	Day		20:58 H
	/Medic Examir		4a. Facility Name (If not institution			<del>-</del>	4b. City, Tox	wn, or Location of De			County of Death	
			Peninsula legio	mal Das	tical (	antor	50	1:chin			11/:00	aica
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		rs. 8. Date of Bir	rth	9. Birth	pplace (State or Foreign intry)
	Director		165-24-4101	1 □ M 2 <b>/</b> F	73	Yrs.	Months D	ays Hours Mi	n. (Month, Da	ay, Year)		
			Usual Residence of Decedent		1.5				July 4	, 193	or Leu	nsylvania
	larylan show		10a. State 10b. County		10c. Cit	ly, Town or Lo	cation					10d. Inside City Limits
	Mar Mar	į	Pennsylvania Leb	anon	F	Richlar	nd					1 X Yes 2 □ No
	be filed within 72 hours after death with the Maryland ital Hygiene. Up the matural, or items 23a or 28a-f show event, the Medical Examination is the multified at	Director	10e. Street and Number				10f. Zip Co	nde		10g. Citiz	zen of What Cou	untry?
	3a o	0	12 Chestnut Str	oot.			1708	7			TIC A	
	death	Funerai	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.1	Was Deceden	of Hispanic Origin?	(Specify Yes or No	2- 1	USA 14. Race - Amer	ican Indian
(0	rite r	ᆵ	1 ☐ Never Married 2X Marri	Armed F ed 1 ☐ Yes	orces? 2 📉 No	1	f Yes, specify	Cuban, Mexican, Pue	erto Rican, etc.)		Black, White	
33	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive		1□Yes 2💢	No Specify:			Specify:	White
21215-0036	72 hours after death w "natural", or items 23a	ed	15. Decedent	's Education		16a. Dece	dent's Usual O	occupation		16h Kir	nd of Business/li	
15	nin 7.	Completed	(Specify only highes	1		(Give	kind of work a DO NOT use r	one during most of westired)	rorking			dostry
12	the ene	E G	Elementary/Secondary (0-12)	College	(1-4or 5+)			,				
9	filled Hyg ther	Ö	17. Father's Name (First, Middle, I	Last)		Beaut	ician	18. Mother's N	ame (First, Middle		ervice	
an	and Mental Hygiene. Is marked other than aumatic evant, I to M	o B	Tueblesse	D-1-1	-14				(,,		,	
₹	d Me mark mati	ř	Luther  19a. Informant's Name/Relationsh	Fitter	riing	10h Mailie	Address (C	Mary	Cum I Day to Muse to		ssler	
Maryland	nd 2 suith an 27 is i							treet and Number or I				
	a a E E		Samuel Seldomri 20a. Method of Disposition	dge (hus	sband)	12 C	hestnu	t Street,				
ō	ges 1 ar t of Hea if item or othan		1 Burial 2 Cremation	3 □Removal from	State	Place of Dispo cemetery, crem	natory or other	r place)	Date	20c. Loc	cation - City or T	own, State
Ë	men tant:		`4 Donation 5 Dother (Sp			nland Ce	metery	September	8,2004 R	ichlar	nd, Pennsy	ulvania
Baltimore,	permit. Pages 1 Department of F important: if ite any injury or ot	-	21. Signature of Funeral Service L	icensee		22 H	Name and A	ddress of Facility	Home Pro	face	ional As	sociation
	20 F # 9		James At Wo	mpoor.	CFSP	5	Ol Sno	w Hill Roa	d. Salis	hurv	. Marula	and 21804
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the deat	h. Do not ent	er the mode of	f dying, such as cardi	ac or respiratory a	rrest,	/ HOLYIC	Approximate Interval Between
	Physician		Immediate Cause (Final	A		1-1	·	DISSECTI	7001			Onset and Death
	/Medical		disease or condition resulting in death)		(or as a conseq		-116	PISSECII	0/0			
2	Examiner					,	11 OD VIE	PULMONI	204 0	SEAS	-	
01		e l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conseq		or office	La contain	11-7 00	16/5	E	
7	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	00	REPROI	JAC (11)	AC	ACCIPE	1/7			
+ -	icate be executed physician and s the burial-transit	xal	that initiated events resulting in death) Last		(or as a conseq		7/10	ACCIPE	- /			
5.24 68760,	be e					,						
5.5	ficate phys s the	edicai		d								
% XO			IF FEMALE:	220 15 400 0	daama af araana							
% o	attene for us	ician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregna birth 2 ☐ Feta	Ideath 3□	Ectopic pregn			2:	<ol> <li>Date of deliv</li> <li>Month</li> </ol>	ery Day Year
0 0	e de the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Preg 9⊟Unkr	nant at time of d	eath 5	Other (specif	y)		- 9	MOUTH	Day 19a1
P.G	that the death certifed by the attending detached for use a	Physi			******					- 1		
3, 2	Se un e	by	Part II. Other significant conditio	ns contributing to o	death but not res	ulting in the ur	nderlying caus	e given in Part I.	23e. Did t	obacco us	e contribute to t	he cause of death?
J Pro	w requires been sign should be	ed							187	Yes 2□	]No 3∏Prol	bably 4 Unknown
eldomer. Vital Record	¥ 2 3 3 × 3 × 3 × 3 × 3 × 3 × 3 × 3 × 3 ×	ompieted							24a. Was		24b. Were auto	opsy findings available
	The la	E O								rmed?	death?	mpletion of cause of
sela Vital		Ö	25. Was case referred to medical						1 Yes	2 No	1 🗆 Yes	2□ No
10	Physician: this certific ral director,	o B	examiner?	Hospital:		FD/0			eath (Check only o		-	
0) 5	ra the	H	27. Manner of Death			ER/Outpatien 28b. Time of		Other: 4 Nursing	Home 5 Resid	dence 6	Other (Special	(y)
J E	ding I	ation:	1 ☑Natural 5 ☐ Pending		of Injury oth, Day Year)	Injury		Injury at Work?	28d. Describe I	now injury	occurred	
lene ivision	or Attanding after death. Diractor: After in by the fune	ical	2 Accident investig 3 Suicide 6 Could n	ot be				1 ☐ Yes 2 ☐ No	1			
N. S.	o it fe	Certific	4 Homicide determi	ned 286. Place build	e of Injury - At ho ling, etc. <i>(Specit</i> )	ome, farm, stre v)	eet, factory, of	fice	281. Location (5 City or Tox	Street and vn, State)	Number or Rura	al Route Number,
6	spital ours a neral C			l i								
•	Hospitai 24 hours a Funerai I tely filled	dicai	(Crieck Orly 2   Medice	g Physician: To the Examiner: On the b	e best of my kno casis of examina	wledge, death tion and/or inv	occurred at th	ne time, date and place my opinion, death occ	e, and due to the	cause(s) a	and manner as s	tated.
	To the Hospital within 24 hours a To the Funeral C completely filled	0		and mar	nner stated.							
	To To CO⊓	Σ	29b. Signature and title of certifier		0.0			cense number			signed (Month,	
			fent & Wel	war house	Jurg	reon	1	146536		9-=	3 - Anel	
IL DE	2		30. Name and address of person v	who completed cau	se of death (Item	1 23a) (Type, I	Print)			, -	as coop	
10 7	^		30. Name and address of person v  Dr. JenniFer  31. Date filed (Month, Day, Year)  SFP 0.7	wehber	0 1061	nilFor	o steer	t Suite 1	rs 5013	Shew	md:	1 Fac
	≽ Sta	ite	31. Date filed (Month, Day, Year)	32. F	Rigistrar's Signa	ture 4	100	Ver .	1	- V.V.	7166	
	Registr	ar	SEP 0.7	ZUU4 /	-	/-						

		•	1 - For State Registrar	State of	Marylan				lealth a D <i>eath</i>		lental Hy	giene Reg. No.	noi.		00076
	ysicia Nedic		Decedent's Name (First, Middle, Las     Roy Thor		parks						2. Date of De Month Septe	Day	3, 200		3. Time of Death 7:50 A
	amin		4a. Fecility Name (If not institution, give	street and numb	oer)				Location	of Death		4c.	County of De	eth	
			22680 Cedar Lane 5. Social Security Number 6. Se		pt. # Age (In yrs.	403		onard or 1 Year	town	24 Hrs	P. Data of Bi		t. Mai		
Fund Direc				X) M 2□ F	87	Yrs.		Days	Hours	Min.	8. Date of Bi (Month, Do Dec. 6	y, Yeer)	16 M	ich	ce (Stete or Forei ) igan
land	7		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation								. tnside City Limit
Mary 8-f ehe	fleds	to	MD St. Mar	v¹s	T	eonard	ltown								1 ☐ Yes 2 📉 N
ith the	Pare Los	Funeral Director	10e. Street and Number	,		Condi		p Code				10g. Citiz	en of What (	Country	?
s 23s	Tall I	rai	22680 Cedar Lan	e Court			W D		650	-1.0 (0-			ited S		
be filed within 72 hours efter death with the Maryland tall Hygiene. Id other than "natural", or Items 23e or 28e-f ehow	xacioar	by Fun	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Force 1 7 Yes 2 11 Yes, Give Year or Date	es?	.5. 13.	If Yes, sp		Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Black, Wh		
72 hou	lical E	Completed	15. Decedent's Ed	ucation de completed)		16a. Dece	dent's Usi	ual Occupa	ation during mos	t of work	na	16b. Kin	d of Busines	s/Indus	stry
d within 72 hours elf giene.	Mar.	mple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT	use retired	)						
e filed within al Hygiene. other then	ent,	0	17. Father's Name (First, Middle, Last)			Non	-comm	ussi	oned 18. Mothe		cer (First, Middle			ate	s Navy
2 should be and Mental Is marked o	atic ev	To B	Roy Thomas Spar	ks, Sr.					Li	11ia	n Cameı	on			
id 2 should be file th and Mental Hy 27 Is marked oth	reum		19a. Informant's Name/Relationship (7				_				il Route Numb				
, gen	other treumatic		Tami M. Stickell 20a. Method of Disposition	(DAUC	HTER)	Place of Disp	sition (Na	me of			Owings		yland ation - City o		
Pages ent of nt: N I	ry or		1 Burial XXCremation 3 : 4 Donation 5 Other (Specify		ate ,	emetery, cre .nsfie]			, -		2004	Cha	rlott	е Н:	all, MD
permit. Pages 1 a Department of Hee Important: If Item	any inju		21. Signature of Funerat Service Licen  David A. Goff	Taist	MO	1095 2	2. Name a	nd Addres	VWOO	Bri	insfiel Leona	d Fur	neral :	Home	e, P.A.
	4		23a. Pert1. Enter the disease, or confr shock, or heart failure. List only	plications that each	sed the deat	h. Do not en	ter the mo	de of dyin	g, such as	cardiac o	or respiratory a	rrest.		A	pproximate terval Between
Physic /Medi			tmmediate Cause (Finat disease or condition resulting in death)	a. EM	d 5	tage	2	Ct	PF						nset and Death
Exami				Due to (or	as a conseq	uence of).									
P	\$\$	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a conseq	uence of):									
ecuted	-transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C	as a conseq										
ificate be executed physicien and	burial	alE	(	Due 10 (01	as a conseq	derice or).									
tificate 19 phy	as the	ledical		0											
the death certific	ched for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Feta nt at time of d	Ideath 3	∃Ectopic p ∃Other (s	oregnancy pecify)				2	3d. Date of d Month	elivery Da	y Year
hait od t	e deta	by Ph	Part II. Other significant conditions co	ontnbuting to dea	th but not res	ulting in the u	inderlying	cause give	en in Part I		23e. Did	tobacco us	e contribute	to the	cause of death?
v require been sig	a pinous										10	Yes 2□	]No 3□F	robabl	y 4 nknow
aw Is t	N	ompleted									24a. Was	psy	prior to	compl	findings availabletion of cause of
	pag	O									1 Yes	20 No	death? 1 ☐ Ye		□ No
Physician: T	director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	patient 2 🗆	ER/Outpatie	nt 3 D	OA Othe	20	of Death	ne 5 Resi		Other (Sp	acifu)	
Afte	=		27. Menner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of		28b. Time o		28c. Injun Work		:	28d. Describe			- Cony	
	ad in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	f Injury - At ho g, etc. <i>(Specif</i>	ome, farm, st	reet, facto	ry, office			28f. Location ( City or To	Street and wn, State)	Number or F	Rural R	oute Number,
To the Hospitel of within 24 hours af To the Funerel D	oletely fille	edical (	29a. Certifier (Check only one)  Certifying Physics   Medical Example   Medical Exam	ysician: To the b niner: On the bas and manne	is of examina	wledge, deat	h occurred vestigatio	d at the time	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) a date and	and manner a place, and du	as state	nd. e cause(s)
To the within	comp	M	29b. Signature and title of certifier	0.			29	c. License		^ ^		29d. Date	signed (Mor	nth, De	y, Year)
10/			) JUDIO					DU	706	06		Sept	ember	3,	2004
) NV			30. Name and address of person who d					irt T	0075	ad +	m M	1 a.m. 1	20650	1	
	Sta	te	Avani D. Shah, 1	32. R	Strar's Signa		A COL	art L	eonai	ατον	n, Mar	y⊥and	∠065(	,	
Re	gistr	ar	SEP 0 7	2004	maria 1	AP A									

			For State Registrar		Marylan		artment rtificate			ind M		Reg. No.	)()4	29876
	Physicia		Decedent's Name (First, Middle, La  Mend:	st) y Ann Shaf:	for						2. Date of Dea Month Septembe	Day	Year	3. Time of Death 11:50 A M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, 1	Town, or	Location o	f Death	Берестве	_	unty of Death	
			23774 Mill Pond Road				Holly	wood				Sain	nt Marys	
	Funeral			Sex 7	'. Age (In yrs. 4	0	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Day	h y, Yea <i>r</i> )	9. Birth	olece (State or Foreign
	Director		217-68-7596	ILIM ALAF		8 Yrs.					July 12,		Mary	land
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Manyl f sho	٥	Maryland Saint M	2 2017 0		µо11	Lywood							1 ☐ Yes 24 No
	the 28a	Directo	Maryland   Saint Maryland   Saint Maryland   Saint Maryland Number	ai ys		11011	10f. Zip	Code				10g. Citizer	n of What Cou	ntry?
	3a o	D E	23774 Mill Pond Road				20	636					USA	
	deati	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.	.S. 13.	Was Deced	ent of Hi	spanic Original	gin? (Spe	ecify Yes or No- Rican, etc.)	. 14.	Race - Ameri Black, White,	
٥	or ite	F	1 Never Married 2 Married	1 ☐ Yes :	2 📉 No		1 ☐ Yes 2		Specify:				pecify: Whit	
9500-61212	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28e-f show ther than "natural", or items 23a or 28e-f show ant, the Madical Examinar must be mailfied at	d by	3 Widowed 4 Divorced	Year or Da	tes:	1 400 Barre	daada Da							
۲ ک	"nat	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usua kind of wor DO NOT us	k done d e retired	ation Iuring mosi	t of worki	ing	16b. Kind	of Business/Ir	idustry
7	withly ene. than	m d	Elementary/Secondary (0-12)	College (1- 2	4or 5+)		l Clerk		,			Socia	al Servi	ces
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or liems 23a or 28a-f show of other than "natural", or liems 23a or 28ffed at event, the Madical Examinating must be notified at	BeC	17. Father's Name (First, Middle, Las						18. Mothe	r's Name	(First, Middle,			
<u>a</u>	Mental I Merked o	To B	Spencer Joseph Wall	ace					Mary	Edna	Readmond			
Maryland	S D E E		19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street	and Numbe	or Or Rura	al Route Numbe	er, City or T	own, State, Zij	Code)
	D = N =		John Paul Shaffer /	Husband					Road Ho		ood, Mary			
9	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 [	Bemoval from S		Place of Dispo cemetery, crea	osition (Nam matory or o	ne of ther plac	e)	Septe	Date ember	20c. Loca	tion - City or T	own, State
Ĕ	Pages ment of l ant: if it		`4 □Donation 5 □Other (Spec	fy)		ropolita	_			9, 20			dria, Vi	rginia
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		21. Signature of Funeral Service Lice	Hardi	nei J	P.	O. Box	270,	Leona	rdtow	eral Home n, Maryla	ind 206	50	
8760,	Physician /Medical Examiner physician and physician and the printer-fraue the physician and physician and physician and physician physic	dicai Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a Me^	trasa consequence as a	juence of):	allbl					rest,		Approximate Interval Between Onset and Death 3 Years
P.O. Box 6	Attending Physician: The law requires that the death certificate be executed reath.  result.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		nth 2 ☐ Feta ant at time of c	al death 3	∃Ectopic pr ∃ Other (sp					230	d. Date of deliv	ery Day Year
	uires thal signed b	by	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	inderlying c	ause giv	en in Part I		23e. Did t	L		the cause of death? bably 4 □Unknown
Records,	ne law require has been si ge 2 should b	Completed										rmed?	prior to co death?	opsy findings available ompletion of cause of
ā	ictan: The lav certificate has ector, page 2	e Co	25. Was case referred to medical						26 Place	of Deat	1 ☐ Yes	20 No	1 🗆 Yes	2 No
5	ysiclan: The lis certificate hadirector, page	To B	examiner?	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatie	nt 3∏ DC	A Oth	0.00	rsing Ho			Other (Speci	fv)
Division of Vital	nding Phys th. :: After this e funeral di		27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigati	28a. Date of		28b. Time of Injury		8c. Injur Wor			28d. Describe I			-
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 289. Place	of Injury - At h	iome, farm, st	reet, factory	, office			28f. Location ( City or Tox		Number or Rui	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director Completely filled in h	Medical (	29a. Certifier 1 Certifying F (Check only 2 Medical Extone)	Physician: To the aminer: On the ba and mann	sis of examina	owledge, deal ation and/or in	th occurred nvestigation	at the tir	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) ar date and pl	nd manner as	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290		e number				signed (Month	
			Charles (	N. Ber	no TING	).		1)	25	156		Jept	emba	7, 2004
4	isn		30. Name and address of person who Charles W. B	ennett 1	u. D. ,	1184	5 T.	^ve			al, Lu			
	St Regist	ate trar	31. Date filed (Month, Day, Year)	32. R	etrar's Sign	ature	ford							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 12:5 ptember 2004 een /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ba 7. Age (In yrs. last birthday) Baltimore more topkin +1 Year II Under 24 Hrs. If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🗗 F Yrs 1994 216-61-5778 10 Maryland Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Director California Maryland| St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20619 United States 45874 Nolte Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Mever Married 2 Married 1 ☐ Yes 2 ■ No Specify: Black If Yes, Give Year or Dates: ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Student 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jacqueline Shubrooks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45874 Nolte Court, California, Maryland 20619 Jacqueline Shubrooks / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal Irom State Charles Memorial Gdns, 9-10-2004 Leonardtown, Maryland ¹ 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Edward N. Brinsfield M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on-each line. Approximate Interval Between Onset and Death Immediate Cause (Final seek **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner ton Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy 2 Fetal death Year Month Day ŏ 5 Other (specify) ☐Yes 2 No detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ai autopsy performed? Yes 2 No page 2 25. Was case referred to medical examiner? 2 🗆 No certificate 1 Yes 1 Yes filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 FR/Outpatient 3FT DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier Scotember 7, RES- 000 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Bathnore nisten Nelson, MO 600 N. Wolfe 32. Registrar's Signature 31. Date liled (Month, Day, Year) State SEP 9 2004 Registrar

			_ State	te of Maryland		artment tificate			ind M		19 1	101	00070
			1. Decedent's Name (First, Middle, Last)			incate	OI L	Joann		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia	an f		Santilli						Sept 6	, 28o	4 Year	4:40 A.M
	/Medic Examin	- 27	4a. Facility Name (If not institution, give street a			4b. City, To	own, or	Location o	f Death			ounty of Deat	
			St. Mary's Nursi			Leona					St	. Mary	's
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 2 1	7. Age (In yrs. last	Yrs.	If Under 1 Months I	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth Nov 1,	1910	Co	hplace (State or Foreign unity) hington DC
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	cation							10d. Inside City Limits
	Maryl f sho	io	Maryland Calvert	Che	esape	ake F	Beac	h					1 □ Yes 2 □ No
	r 28e	Director	10e. Street and Number			10f. Zip C					10g. Citizer	n of What Co	
	th with	aiD	3400 Brookside Driv	е			20	732			Unite	ed Sta	tes
	r dea	Funerai	Am	s Decedent Ever in U.S. ed Forces?	13. \	Was Deceder	nt of His y Cubar	spanic Orig	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	
36	s afte	by F		Yes 2 <b>XX</b> o es, Give ir or Dates:		I□Yes 2	ZXNo	Specify:			Sp	pecify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-f show the McJical Examiner must be notified at	ted t	15. Decedent's Education	1	6a. Deced	lent's Usual	Occupa	tion			16b. Kind	of Business/l	Industry
215	hin 72 3. 9n "ne	Completed	(Specify only highest grade comp	ege (1-4or 5+)	(Give life. L	kind of work DO NOT use	done di retired)	uring most	of worki	ng			
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nd	be file	Be	17. Father's Name (First, Middle, Last)							(First, Middle,		mame)	
Z S	d Men narke	٦	Antonio Santilli  19a. Informant's Name/Relationship (Type, Pri	17)	10h Mailin	a Address /	Street		enza	a Santi I Route Numbe		our State 3	in Code)
Maryland	d 2 sith an treur		Christine Dewitt (Gr			•							
ľe,	s 1 an f Heal item		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name	of			2004		tion - City or	
E	Page: nent o nt: If ry or		14 Burial 2 ☐ Cremation 3 ☐ Removal 14 ☐ Donation 5 ☐ Other (Specify)	from State		tion (		v ser tery	)L 9,	2004	C1int	on, Ma	arytand
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumetic event, Ite Markleal Examiner must be nutified at any injury or other treumetic event, Ite Markleal Examiner must be nutified at ange.		21. Signature of Funeral Service Licensee										6633 01d
	90 E # 9		Sty Sitty MO	0542								ı, Mary	yland 20735
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ec	aw 1s b	Completed	Agrettenson							24a. Was a autop: perfor	sy		topsy findings available completion of cause of
a E	Th ate pag		Atrial fibrilla	len						1 Yes	2 200	1 ☐ Yes	25 No
Vital	Physicien: 1 this certifical ral director, p	o Be	25'. Was case referred to medical examiner?  1 Yes 2	1 ☐ Inpatient 2 ☐ ER	/Outpatien	t 3 DOA	Othe	r-		(Check only or ne 5 ☐ Resid		70*h /S	
of		<b>-</b>	27. Manner of Death 28a		b. Time of		c. Injury	at		28d. Describe h			iry)
ion	Attending r death. ector: After by the fune	atio	1. Natural 5 Pending 2 Accident investigation	(World, Day Year)	Injury	М	Work¹ 1 ☐ Y	es 2 🗆 N	10				
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	To the Hospitel within 24 hours of To the Funerel completely filled	edical	29a. Certifier (Check only one)	to the best of my knowle the basis of examination dinanner stated.	and/or inv	occurred at vestigation, in	the time	e, date and inion, deat	h occurre	and due to the condition at the time, conditions.	ause(s) and late and pla	d manner as ace, and due	stated. to the cause(s)
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	-		1/			<	0/	991	/		9/8	104	
7	s		30. Name and address of person who complete James C. Boyd, M.D.		Ba) (Type, otch	Print) Road,	Ca1	iforn	ia,	Marylan	d 206	19	
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 8 2004	32. Registrar's Signature	dr.	book	9						

			For State Registrar	State of	Marylar		artmen rtificate				lental Hyg	iene	004	298	7.9
П	Physici	an	1. Decedent's Name (First, Middle, I	.ast)							<ol><li>Date of Deat Month</li></ol>	h Day	Yea	3. Time of	Death
	/Medic		Pearl Edith Sim				1				August			5:41	рМ
*	Examir	er	4a. Facility Name (If not institution, g						Location of	of Death			ounty of De		
			Laurel Regional  5. Social Security Number 6.			last birthday)	La If Under	urel	If Under	24 Hrs.	8. Date of Birth	Pr		George's	
	Funeral Director		214-34-7198	1 M 2 XF	92	Yrs.	Months	Days	Hours	Min.	(Month, Day, Aug. 27	Year)	1	Country) North Dak	
	ס		Usual Residence of Decedent									,			
	ahow a show	_	10a. State 10b. County			ity, Town or Lo	cation							10d. Inside Cit	1
	8a-1.	cto		e George'	S		Laure							1 X Yes	2   NO
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	r Itam	Ë	1 □ Never Married 2 □ Married	Armed Ford	:es? !∭No			37			ecify Yes or No- Rican, etc.)		Black, W		
3	al', o	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:		1 ☐ Yes	2 <b>⊠</b> No	Specify:			5	Specify:	White	
2	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show Ita Madical Examirer must Le nutilled at	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa nk done d	ition Juring mos	t of worki	ng	16b. Kin	d of Busine.	ss/Industry	
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7	Hygie Hygie ther t		17. Father's Name (First, Middle, La	st)		Home	maker		18 Mothe	ar's Name	(First, Middle, N		n Hon	ie	
and	d be f	) Be	Rudolph Urban								ngston	ididoir c	arramo,		
Maryland	shoul nd Me mark	으	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a			I Route Number,	City or	Town, State	a, Zip Code)	
Š	nd 2 alth a 27 is		Marilyn S. Phel	ps – Daug	hter	205	Cherr	y Hi	.11 La	ane.	Laurel,	Mar	vland	20724	
e,	of Hei		20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of						or Town, State	
Ē	Page nent ant: If ury or		1 XBurial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe		Fo	rt Lin	coln (	Ceme	tery	9/4/	2004	Bre	ntwood	d, Maryla	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any figury or other traumatic evant, the Medical Examiner must be nutified at once.		21. Sign up of Fur ral Service Lic	enede	400	1 -					sch's Fu			•	_
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			23a. Fart1. Enter the disease, or co shock, or heart failure. List of	y one cause on ea	used the dea ch line.	th. Do not ent	ter the mod	e of dying	g, such as	cardiac o	r respiratory arre	est,		Approximate interval Betw Onset and D	veen
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	/Medical Examiner			Due to (o	r as a consec	quence of):									
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9	death certifice e attending ph id for use as tl	Med	IF FEMALE:	00- 11											
Вох	leath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		th 2 Fet	al death 3	Ectopic pr					23	ld. Date of o Month	,	ear
		Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregnal 9⊟Unknov	nt at time of o	death 5L	Other (sp	өспу)							
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sp.	uires 1 sign 1d be	d by	Congestive Hear	t Failure	1						1 ☐ Ye	s 2 🛚	No 3 □	Probably 4 🗆 U	nknown
Ö	w require s been si should I	iete	Asthma								24a. Was ar		24b. Were	autopsy findings a	vailable
Be	0 4 0	Completed	Alzheimer's Dis						-		autops perform 1 Yes 2		prior t death 1 🔲 Y		use of
ital	ician: Th certificate ector, pag	0	25. Was case referred to medical	ease					26. Place	of Death	(Check only one				
<b>&gt;</b>	N S	To B	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 ☐ Inj	oatient 2X	ER/Outpatier	nt 3 DC	Othe	er: 4 □ Nu	rsing Ho	me 5 🗆 Reside	nce 6	□Other (Sp	pecify)	
0 0		on:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury		8c. Injury Work			28d. Døscribø ho	w injury	occurred		
Sio	Attending or death. ector: After by the fune	ertification:	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	ha	Alaina Akh		M		/es 2 □ I	-	296 Lagation /C4		A/	Down I Downto Africa	
Division of Vital Records,		ertif	4 Homicide determine	288. Place o	g, etc. (Speci	nom <i>e</i> , farm, str ify)	eet, factory	r, office		1	City or Town		Numper or	Rural Route Numb	) <i>01</i> ,
_	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	O	29a. Certifier 1 X Certifying (Check only 2 ☐ Medical Ex	Physician: To the b	est of my kn	owledge, deat	h occurred	at the tim	e, date an	d place, a	and due to the ca	use(s) a	nd manner	as stated.	
	To the H within 24 To the Fi complete	fedical	one)	aminer: On the bas and manne	or stated.	and and of th									
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	1110		Mr	290	. License		40				nth, Day, Year)	0011
,	-		()1	VV	)	טויו		DE	567	17	5	CY16	TIMBE	R 1,2	100
0	R1251		30. Name and address of be son wh	io completed cause	of death (Ite	m 23a) (Type,	Print)	n	aí	20	707				
	Sta	ate.	31. Date filed (Month, Day, Year)	A. Re	gistrar's Sign	LAU	40	111	וון	00	107			V	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 1:45P M Theresa Serene September 2,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5-A Plateau Place Greenbelt Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔏 F 59 195-34-6769 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Prince Georges Md. Greenbelt Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 5-A Plateau Place USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Case Manager Social work 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Andrew Shushock Anna Yuhaniak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Serene - Son 2121 Folkstone Road, Timonium, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 09-08-04 5 1 ☐ Burial 2 TCremation 3 ☐ Removal from State Alexandria, VA. permit. Page Department of Important: if any injury or once. Metropolitan Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Fryice J. 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715 Approximate Interval Between user and Dorn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sunsequence of): been signed by the attending physician and should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Yunknown Completed certificate has been rector, page 2 should 24a. Was an autopsy performed?
1 Yes 2 No ✓24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No To the Hospitel or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 SNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Al investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 0 02055Z 104 926 Wayaull 30. Name and address ause of death (Item 23a) (Type Ica 31. Date filed (Month, Day, Year) Registrar's Signature-State 7 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:23 PM AUG 2004 Edward J. Struble 29 /Medical 4a. Fecifity Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Howard County General Hospital Columbia Howard 7. Age (In yrs. last birthday) Under 1 Year If Under 24 Hrs. onths Days Hours Min. Birthpface (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 158 M 2□ F June 9, Indiana 1952 Director 217 56 3445 52 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County "natural", or iteme 23e or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo by Funeral Director MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 United States 3963 Weavers Court death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. tem 27 is marked other then "natural", or ite wher traumatic event, the Medical Exemination. 1 Never Married 25 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1970-75 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coflege (1-4or 5+) Construction Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a fitem 27 is r other tra Linda C. Struble/Wife 3963 Weavers Court Ellicott City, MD 21043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State = 5 permit. Page Department of Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. 9-2-2004 Crownsville, MD 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 0 ded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fine. 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Approximate fntervaf Between Onset and Death Atherosclevotic Cardiovascolar Discos Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the i 9 Unknown à signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 4 EUnknown 1 🗌 Yes 2 🗆 No 3 🔲 Probably NOV peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed? res 2 12 Ne certificate 1□ Yes Division of Vital After this certification funeral director, i To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Yes 2 No 2 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: Injury Natural 5 Pending 1 Tyes 2 🗆 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031473 a W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemlock Cone way Elliat 107 MY 31. Date filed (Month, Day, Year)
SFP 0 1 PATRICE 4565 State SEP 0 Registrar

			1 - For State Ragistrar		faryland / Dep	artment ertificate			and M		Reg. No.		29882	
	Physici	an	Decedent's Name (First, Middle,							2. Date of De Month	oer 2, 2	Year	3. Time of Death	
	/Medic	al	Charles	Francis		vens				Septem			4:30P N	4
1	Examin	ier	4a. Facility Name (If not institution, Frederick Memory	*		4b. City, 1			of Death		4c. County			
-	Euroval				ge (In yrs. last birthda		deri	If Under	24 Hrs.	8. Date of Bir		deric		
	Funeral Director		046-20-2651 Usual Residence of Decedent	1 <b>3</b> M 2□F	76 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da JAN 2	y, Year) 1928	Cour	lace (State or Foreig htry) MA	
	yland		10a. State 10b. County		10c. City, Town or	Location				<del></del>		1	0d. Inside City Limits	 S
	Mar B-f st	tor	FL ST. 1	LUCIE	FT. PI	ERCE							1 Yes 2 □ No	)
	or 28	Oire	10e. Street and Number			10f. Zip	Code				10g. Citizen of	What Cour	itry?	
	ath w	rai	14001 CISNE (				3495				US	SA		
9036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show Is Modical Exiz. viller i: ust be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 NYes 2 If Yes, Give Year or Dates:	1 Ever in U.S. 1 1945 1 51 - 1 54	. Was Decede If Yes, speci 1 Yes 2	. 1	spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac Specify	e - Americ ck, White, ''' WH]	etc.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if Item 27 is marked other then "naturel, or Items 23a or 28e-f show any Injury or other treumatic event, If a Marical Extention and be nuffilled at once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or	(Girls life	edent's Usual re kind of work DO NOT use	k done du e retired)	tion u <i>ring mo</i> si OACH		ng	16b. Kind of B PUBLI SYSTE	C SC		
פ	e filed al Hygid other vent, I	Bec	17. Father's Name (First, Middle, L.	ast)				18. Mothe	r's Name	(First, Middle,	Maiden Surnan	78)		_
Vlai	should be nd Mental marked o	To	CHARLES FRAN	CIS STEV	ENS, SR.			BLA	NCH:	E LOVE	LY			
Maryland	2 shc 1 and 1s m		19a. Informant's Name/Relationshi								ar, City or Town,			
	1 and Health em 27 ther to		MARGARET STEV  20a. Method of Disposition	ENS / SPO	OUSE 140			CIR	No. of the last of	, FT.	PIERCE	-		
Baltimore,	Pages nent of H ant: If Ite		1 Burial 2 Cremation :		nomoton, of	ematory or oti	her place	T.	9/7		BARNE		LE, MD	
Balt	permit. Page Department of Importent: If any Injury or		21. Signature of Uneral Persice L	1		HILTO	N F	UNER	AL I	HOME	T.T. M	_ 2	0838	
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each	ed the death. Do not e	nter the mode	of dying	, such as	cardiac o	r respiratory a	rest,		Approximate Interval Between	_
	Physician		Immediate Cause (Final disease or condition	Ru	espirator	, Fai	· Lui	12					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):	71								_
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	ted nsit	nine	Sequentially list conditions, large terminations, cause. Enter Underlying Cause (Disease or injury	03010 (0131	Puln	0)000		7,50						
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P.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as!	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pre □ Other (spe					23d. Dat Mo	e of delive	ry Day Year	
	uires that i slgned b id be deta	þ	Part II. Other significant condition				use giver	n in Part I.			obacco use contr		e cause of death?	ı
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Division of Vital Records,	The lav	Completed								autop perfo	sy p	rior to con leath?	pletion of cause of 2 No	
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of	Physi this al dir	10	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpati			Other	4 🗆 Nur			ence 6 Oth		)	
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Si	Attendi death. ctor: A y the fu	fica	2 Accident investiga 3 Suicide 6 Could no	ot be as Place of In	njury - At home, farm, s			03 2		8f. Location (S	treet and Numb	er or Rural	Route Number	_
<u>&gt;</u>	after after Dire	Certification	4 Homicide	building, e	itc."(Specify)	,,	000			City or Ton			riodio ridinosi,	
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Cartifying 2 Medical Ex	Physician: To the best kaminer: On the basis of and manner s	of examination and/or i	ith occurred a nvestigation, i	t the time in my opi	s, date and nion, deat	d place, a	and due to the dead at the time, d	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)	_
	To th within To the compl	Me	29b. Signature and title of certifier			29c.	License	number			29d. Date signed	(Month, E	Pay, Year)	
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	1.		30. Name and address of person w					J 0	Z U			, 0 7		_
	V		D. AGYAKO-WI	REDY, MD	400 W.	7th s	TREE	ET, I	ERED	ERICK	MD 2	21701		_
*	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	5	don	who .						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** 28° 2004 Louis J. Saia August 11:25p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year)
Feb. 6, 1914 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 ☐ F 90 213-03-6310 Yrs. Maryland **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show ast be notified at MD Anne Arundel Annapolis 1 ☐ Yes 2 TNo Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1304 Swan Drive 21401 USA Funeral 14. Race - American Indian, Black, White, etc. 'naturel', or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status or other treumatic event, It we Madical Exp. ili er r. filed within 72 hours after Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry American Plate and Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wir Department of Health and Mental Hygient Importent: if item 27 is marked other the eny injury or other treumatic event Defense Contractor 12 Dial Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Saia Josephine Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alverta E. Saia/Wife 1304 Swan Drive Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Louden Park Cemetery 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Fhysician 1 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Line of declying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) Examiner attending physician and for use as the burial-transif Records, P.O. Box 68760, Physician/Medical use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Inpatient 1 ☐ Yes 2 🕰 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3∏ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: al or Attending F after death. I Director: After After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel E

completely filled i To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (them 23a) (Type, Print) 12 ROBERT ( MODE 31. Date filed (Month, Day, Year) strar's Signature State SEP 0 1 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Mary Snyder 30, Aug. 2004 4:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 781 Riverside Drive Arnold Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, May 11, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 ☑ F 90 Director 168-24-543<u>1</u> PA Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits rel', or Items 23a or 28e-f ehow Exeminer aust be notified at Anne Arundel Director Arnold 1 ☐ Yes 2 No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 781 Riverside Drive 21012 USA Completed by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify Specify: White 3 AWidowed 4 ☐ Divorced "neturel" The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) then College (1-4or 5+) Homemaker Home 12 filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ages 1 and 2 should be find to the distributed Health and Mental Hit: If Item 27 is marked oil yor other treumatic every Jan Zvolenik ဥ Anna Mokris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Miller/Daughter 781 Riverside Drive Arnold, MD 21012 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite any injury or ott 2, Sept. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Johns Cemetery Courtdale, PA \* 4 Donation 5 Dother (Specify) 2004 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, priesary ailure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Approximate Interval Between Onset and Death DISEMSE **Physician** ZIOYEXES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). death certificate be executed use as the burial-trai resulting in death) Last Due to (or as a consequence of): nding physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy φ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 0 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by the ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 516 MOID 1 Yes 2 No 3 Probably 4 Hhknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ★10 page 2 autopsy performed? 1 🗌 Yes 2 No Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 21 No 2 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After or Attending Injury 1 Natural 5 Pending investigation after death.

Director: Af
d in by the ful 1 TYes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel E filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D37089 30 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYVIEW CR PASSIS ON FROMORAS 2201 32. Redistrar's Signature 31. Date filed (Month, Day, Year, State 2004 Registrar

AKG	2021			Please		Int in Black in				_	e.	
			For State		State of IV	laryland / Depa <i>Cei</i>	rtificate of			eg. No. O O	29885	
•			Registrar  1. Decedent's Name (Fig. 1)	First, Middle, La	ast)		tinodito or		2. Date of Dea	th	3. Time of Death	_
	Physicia /Medic		Joseph		W	Sullivan			Month September		004 4:45 P	M
7	Examin		4a. Facility Name (If not	-		)		r Location of Death		4c. County of [		
			10207 St.  5. Social Security Numb			ge (In yrs. last birthday)	Cumber 1 Year		8 Date of Birth	Alleg		ian
	Funeral Director		215-88-72 Usual Residence of De-	245	1□ <b>X</b> M 2□ F	49 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan 31	, 1955	Birthplace (State or Foreig Country) MD	911
	the Maryland 28a-f show nutified at	or		Allega	any	10c. City, Town or Lo	berland				10d. Inside City Limit 1 ☐ Yes 2 ☐ N	
	with the ta or 28a.	Funeral Director	10e. Street and Numbe 10207 St.		rive NE		10f. Zip Code	21502	1	0g. Citizen of Wha		
	death ms 2%	hera	11. Marital Status		12. Was Deceden	t Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - A	American Indian, White, etc.	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 Is marked other than "natural", or Itams 23a or 28a-f show other traumatic evant, If a Musical Examination in the nutility of the commentation of the contraction of the c	by Fur	1 Never Married 3 Widowed 4		1 XYes 2 If Yes, Give Year or Dates	1072 1074	1 ☐ Yes 2 No	Specify:	nican, etc.)	Specify:	white	
215-0036	within 72 ho ene. than "natur i e Madical	Completed by	15. (Specify of Elementary/Seconda		Education rade completed)  College (1-40)	(Give	_	during most of work d)	ing	16b. Kind of Busin	ess/Industry	
2	filed with Hygiene. Ithar thai	Con	12			Lance	Corporal			Marine Co	orps	
and	be fill Hall Hall Hall bad offh	Be	17. Father's Name (First John A.					18. Mother's Nam	A. Rizer	•		
Maryland	2 should to and Ment Is markac	٦	19a. Informant's Name Wanda Do	a/Relationship				and Number or Run Vit. Rd. SE	al Route Number	170 353	te, Zip Code) MD 21502	
	s 1 and if Health item 27 other tr		20a. Method of Disposi			20b. Place of Dispo	sition (Name of	1 1	Date	20c. Location - City		_
υČ			1 ☐ Burial 2 ☐ C	Cremation 3	☐Removal from State	<sup>e</sup> Rocky Gap	natory or other place Veterans C	cemetery	9/17/2004	Flintston	e MD	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signarore of Funer			1000 - 22		ili Funeral Hoginia Avenue				
	16		23a. Part 1. Enter he o	disease, or cor	mp cations that cause y one cause on each	e the death. Do not ent					Approximate Interval Between	
J	Physician		Immediate Cause (Fin disease or condition		COTO	vacua and	era H	hromba	7.1		Onset and Death	
1	/Medical- Examiner		resulting in death)	(	Due to (or a	s a con (equence of):		diovas		(1000		
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	uted d ansit	Examiner	Sequentially list condit if any, leading to immediate Enter Underlying Cause (Disease or injuthat initiated events	any								
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	ate be ex physician the buria	dical			d			<del></del>				
89 X	leath certificate t attending physic for use as the t	/Mec	IF FEMALE:		23c. If yes, outcom	ne of pregnancy				23d. Date of	f delivery	
. Box		Physician/Medi	23b. Was decedent proint the past 12 mo 1 ☐ Yes 2 ☐ N	onths?	1☐Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)	у		Month	Day Year	
P.0	at the ded by the etached	Phys	9 Unknown			had and annulting in the		and a Breat	220 Did to	hagan una gantribu	te to the cause of death?	_
	The law requires that the te has been signed by th age 2 should be detache	by	Part II. Other significa	int conditions	contributing to death	but not resulting in the u	nderlying cause giv	ven in Part I.			Probably 4 Unknow	vn
50	w requir s been si should	ompleted							24a. Was a	ın 24b. Wer	e autopsy findings availab	)le
of Vital Records,	The lav	omb							autops perfor	med? deat	r to completion of cause of ∤n? Yes 2 No	ſ
/ital	iician: Th certificate rector, pag	BeC	25. Was case referred examiner?	I to medical				26. Place of Deat				
of \	Phys this aldin	J.	Yes 2 No 27. Manger of Death	N ===	Hospital: 1 ☐ Inpa 28a. Date of In		IL 3 DOA		ome 5 Reside	ence 6 Other (	Specify) at scene	
On	ding I h. After funer	tion		5 Pending	(Month, E	Day Year) Injury	Wo	rk? ]Yes 2 □ No	200. Describe III	ow injury documed		
Division		Certification:		6 Could not determine	be 28e. Place of I	njury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Number on, State)	or Rural Route Number,	
1	Hospital 4 hours Funeral ely filled	Medical Co				st of my knowledge, deat of examination and/or in						
	To the within 2 To the complet	Mec	29b. Signature and title	e of certifier	and manner	O	29c. Licens	se number	2	9d. Date signed (A	fonth, Day, Year)	
	- × - ŏ		MAT	. 0	1 0m. 1	-Polle	C.C.M.	.E.	s	eptember	13, 2004	
/	2-1A)		30. Name and address	s of person wh	o completed cause of	death (Item 23a) (Type,	Print)			-		
_	111	- 40	HATRIC	A Ai	MONICA	strar's Signature	111 Per	n Street,	. Baltim	ore, Mary	land 21201	
\$	Sta Regist	ate rar	31. Date filed (Month,		004	General Solution	gete!					

		•	For State Registrar	State of	Maryland / [	Departme Certifica			and M		ieņe <sub>eg. No.</sub>	) 4.	29886
	Dhusisi		1. Decedent's Name (First, Middle	e, Last)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio			ilomena Te						Septemb	-	004	13:15 M
	Examir	er	4a. Facility Name (If not institution					r Location o	of Death		4c. County		
			1162 Ebenezer				sing	Sun If Under 2	04 140		Cec		
	Funeral		5. Social Security Number 132–03–0828	4 17 14 0 177 1	'. Age (In yrs. last bir. 86	Yrs. Month	er 1 Year Days	Hours	Min.	8. Date of Birth (Month, Day,	Year) 1918	Coun	lace (State or Foreign try)
	Director		Usual Residence of Decedent							April 2	, 1910	Mass	achusetts
	/land		10a. State 10b. County		10c. City, Town	n or Location						1	0d. Inside City Limits
:	Man Med sh	to	Maryland Ceci	1	Elkt	on							1 ☐ Yes 2 🙀 No
	ith the Marylan or 28a-f show	Director	10e. Street and Number				ip Code			1	0g. Citizen of	What Coun	try?
	15 with with 23 a c		202 Elkmore Ro	ad		2	1921				United	d Sta	tes
	ems ems	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S.	13. Was Dec	edent of H	ispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		e - Americ	
98	or it	y Fu	1 Never Married 2 Mar	ried 1 ☐ Yes 2	2 ሺ No		2 X No	Specify:		,	Specif	v·	
8	ural,	d by	3 X Widowed 4 □ Divorced			Desertable H		!			10h Kind -1 D		ite
-5	filed within 72 hours after death with the Maryland Hydiene. Hydiene. Inter them "natural", or Items 23e or 28e-f show ent, Ite Maulcal Examinar must be molified at	Completed	(Specify only highe	nt's Education est grade completed)	16a.	Decedent's Us (Give kind of v life, DO NOT	uai Occup rork done i use retirec	ation during most ii)	t of worki	ng	16b. Kind of B	usiness/ind	lustry
12	withi ene than	щc	Elementary/Secondary (0-12)	College (1-4	4or 5+)	Homema		,			In Her	Own	Home
b	filed Hyg other ent,	Be C	17. Father's Name (First, Middle,	Last)	-	11011101110	, LCL	18. Mothe	r's Name	(First, Middle, M			. IOIIIC
an	should be nd Mental marked o	To B	Luigi Morse					Phil	omer	na Gallo			
ary	shor and N ama uma		19a. Informant's Name/Relations	ship (Type, Print)	19b	. Mailing Addre	ss (Street	and Numbe	r or Rura	Route Number	City or Town,	State, Zip	Code)
Σ	and 2		Ralph J. Terra	cciano/Son	. 20	02 Elkm	ore F	Road,	Elkt	on, Mar	yland 2	21921	
ore	es 1 a of He of He ritem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demoval from S	camatai	f Disposition (N ry, crematory o	ame of other plac	(a) S		mber	20c. Location -	City or To	wn, State
Ĕ.	Pages nent of I ant: If it ury or o		'4 □ Donation 5 □ Other (5			ah Ceme		;1	1, 2	004		ı, Ne	w Jersey
Baltimore, Maryland 21215-0036	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show lany injury or other traumatic event, the Medical Examinar must be notified at once.		21. Sign Jure of Funeral Service	Licensee	-	22, Name Hicks	and Addres	ss of Facility	y Fune	rals, P	Δ.		
ш_	20 E # 9	21 13	Donne -	8 Dul	$\sim$	103 W	. Sto	ckton	Str	eet, El	kton, M	Maryla	and 21921
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that car tonly one cause on ea	used the death. Do i ch line.	not enter the m	ode of dyin	g, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
F	nysician	0. 1	Immediate Cause (Final disease or condition	_ a D	em enti	a							12075
	/Medical Examiner		resulting in death)	Due to (o	r as a consequence	of):						/	
		<u></u>	Sequentially list conditions,	b. — Due to (c	or as a consequence	of)·						-	
N	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<		/-							
T.	be executed sician and burial-transit	хаг	that initiated events resulting in death) Last	c. Due to (o	er as a consequence	of):							
8760,	ate be executed hysician and the burial-transit	dicai E		d									
		edic											
Вох	eath certific attending p for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy th 2 Petal death	3 □Ectopic	oreonancy	,				te of delive	
œ.	deat	sicia	in the past 12 months? 1 ☐ Yes 2 🐪 No		int at time of death	5 Other					Mo	onth	Day Year
P.0	at the	hys	9 Unknown										
s,	res that the death cer igned by the attendin be detached for use		Part II. Other significant conditi	ons contributing to dea	ath but not resulting in	n the underlying	cause giv	en in Part I.					e cause of death?
ord	w requir been si should	ted								1 🗆 Ye	s 2 KNo	3 LI Probi	ably 4 Unknown
e C	e law r has be je 2 sh	Completed								24a. Was a autops	n 24b. 1	Were autor	osy findings available apletion of cause of
E	The	Con								perform 1 Yes 2	No No	death? 1 🗌 Yes	2 No
Vital Records,	ilcian: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:			Oth	0.0		(Check only on			Lacited
of	Phys this al dir	2	1 Yes 2 No 27. Manner of Death	1 U In	patient 2 ER/Ou	tpatient 3 1	, OA	4 🗆 1401		ne 5 Reside			Living
L	ding f	tion	1 Natural 5 ☐ Pendi	ng 28a. Date of (Month)	, Day Year)	njury M	28c. Injun Worl	k? Yes 2 □↑		.04. 20301104 110	w mjury cocur		i-westity
Division of	l or Attendi after death Director: A	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of	of Injury - At home, fa					28f. Location (St.	reet and Numb	er or Rura	Route Number,
Div	after Dire	Certification:	4 Homicide	building	g, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Town	, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical C		ng Physician: To the base and manner	sis of examination an								
	ompl	₹ E	29b. Signature and title of certific	er /		2	9c. Licens	e number		25	9d. Date signe	d (Month, L	Day, Year)
			VIII - 40	Mus.	117		DI	53	14	<	ientem	her	17.2004
-	11		30. Name and address of person	who completed cause	of death (Item 23a)	(Type, Print)	<u> </u>	//	,	1	-10		17,2004 Kron, MD
			H Farka	ing,	Scasuns 1	Not	1h ar	n a	reja	y calle 1	to spice	, 21	Kron, MD
		ate	31. Date filed (Month, Day, Year	004 32. Re	gistrar's Signature	Coaste			-	,			,
	Regist	rar	AF1 % T (		/								

December State of Parts Associated April 10   December State of				For State Registrar	State of Ma	•	Departmen Certificate					Reg. No.	and the same of th	29887
Final Director    Final Director		•	_		at)	T	URNER					Day	~	
State   Part of the Committee    }			4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	Death	0	4c. Count	y of Death		
Physician   Phys		F			al Nedica	e (In yrs. last bir	thday) If Under				B. Date of Birt	th		
16.0, Carley   16.0				245-52-7580			Months	Days	Hours	Min.	Nov. 3	y, Year) , 1934_	Nor	th Carolina
Committee   Comm		nyland how				10c. City, Tow	n or Location						1	
Committee   Comm		the Ma	ecto		0	Nantic		Code				10a Citizen of	What Cour	
Committee   Comm		with Sa or			ne				1					
Committee   Comm		death	era		12. Was Decedent	Ever in U.S.				in? (Spec	ify Yes or No		ce - Americ	
Committee   Comm	36	s after , or Ite			1 ∐Yes XXIII If Yes, Give					Риело н	ican, etc.)			
Committee   Comm	9	ture!	ed b			16a.	Decedent's Usua	al Occupa	ation					
Spring   S	21215	d within 72 gione. r than "ne rne Medis	omplet	(Specify only highest gra	de completed)	5+) CU		rk done d se retired,	furing most o	of working	g	Wicomi	co Co	unty
Spring   S	land;	uld be filed fental Hyg rked othe tic event,	Be								(First, Middle,			
Spring   S	Aary	2 short and N ls ma										1000	one and the same	The control of the co
The Bursal 2   Commission   Same		s 1 and f Health Item 27 other t		20a. Method of Disposition		20b. Place of cameter	624 Mad Disposition (Name ov. crematory or o	Calf	Lane					
Physician (Medical Examiner 1997)  Physician (Medical Examiner 1997)  Physician (Medical Examiner 1997)  Physician (Medical Examiner 1997)  Physician (Medical Examiner 1997)  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II Other significant conditions contributing to the cause of death?  Part II Other significant conditions contributing to the cause of death?  Part II II II II II II II II II II II II II	E S	Page nent o ant: If ury or							i	9/04/	2004	Hebron,	Mary	land
Approximate the disease or completed that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest.  Approximate the disease or completed that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest.  Approximate that the disease or completed cause (final importance of the death).  The disease or completed cause (final importance of the death).  The disease or completed cause of the death of th	Balt	permit. Departr Importe eny inji		21. Statur of Funeral Service Licer	So Jalle	41						ey Road	-Sali	
Reduced Examiner   Part   Pa		Physician		shock, or heart failure. List only Immediate Cause (Final	one each li	the death. Do				ardiac or	respiratory a	rrest,		Approximate Interval Between
FFEMALE:   23b. Was deadednt pregnant in the past 12 myorins?   1   1   1   1   1   1   1   1   1	760,	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c			ato	5 7	ጎሮ	21			
25. Was case referred to medical examiner?  10 yes 2 yes yes yes yes yes yes yes yes yes yes	O. Box 6	the death certifica y the attending ph sched for use as th	nysician/Medl	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death								
25. Was case referred to medical examiner?  10 yes 2 yes yes yes yes yes yes yes yes yes yes		luires that n signed b	b	Part II. Other significant conditions of	ontributing to death b	out not resulting	n the underlying c	ause give	en in Part I.					
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Place of Death (Check only one)  28. Place of Death (	I Reco	10	Complete								autop	rmed?	prior to col death?	impletion of cause of
The state   The	/ita	iclen: sertific ector,		examiner?	Hoenital:			Othe	\F:					
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29a. Certifier (Check only only 1 depth of certifier (Check only only 1 depth of certifier (Check only only 1 depth of certifier (Check only only 1 depth of certifier (Check only only 1 depth of certifier (Check only only only 1 depth of certifier (Check only only only only only only only only	Divisi	in the	ertifica	3 Suicide 6 Could not b	e 28e. Place of Ini	jury - At home, fa tc. <i>(Specify)</i>	ırm, street, factory	, office		28	3f. Location (S City or Tox	Street and Num vn, State)	ber or Aura	I Route Number,
Name and address of perso, who completed cause of death (Item 23a) (Type, Print)  Nitchell Sittelman 100 E. Carroll St. Salisbury MD 21804  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		e Hospits o 24 hours e Funerel letely filler		(Check only 2 Medical Exam	niner: On the basis of	of examination ar	e, death occurred ad/or investigation	at the tim , in my op	ie, date and pinion, death	place, an	nd due to the	cause(s) and m date and place	nanner as si , and due to	tated. the cause(s)
State 31. Date filled (Month, Day, Year) 32. Registrar's Signature		To th withir To th comp	Me	29b. Signature and July of certific	11-	7 6	290	: License	548	325	7	29d. Date sign	ed (Manth,	Day, Year)
State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	1/1	a		M. Name and address of perso who	completed cause of o	death (Item 23a)	(Type, Print)	· · ·	, -			ma	2/1	20/
	107				1	rar's Signature	4 1		r. X	1115	oury	1110	0/18	

Sarah TURNER

948.84.7580

		,	Certificate of Death	Reg. No.	2004 29888
	Dhamisian	1. Decedent's Name (First, Middle, Lest)		2. Date of Death Month Day	3. Time of Death
-	Physician /Medical	Lanat Laa Thomas		Sept. 8	2004 8:40 AM
	Examiner	An English Nome of front in addition of the stands and according	4b. City, Town, or L	ocation of Death 4c. (	County of Deeth
		18033 Putter Drive	Hagerst	own V	Vashington
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs.		8. Date of Birth (Month, Day, Yeer)	Birthplace (State or Foreign Country)
	Director	481-26-5964 <sup>1□ M 2</sup> 77	Yrs. Substitute Suys   118818	June 2,192	7 Iowa
	p ,	Usuel Residence of Decedent			
	aryle		y, Town or Location		10d. Inside City Limits
	Se-f	Maryland Washington	Hagerstown		1 ☐ Yes 2 💢 No
	vith the Ma	10e. Street end Number	10f. Zip Code	10g. Citiz	en of What Country?
	ath with the Marylence 23a or 28a-1 show rust be notified at any long the contractor.	18033 Putter Drive	21740		S.A.
	r tems 23s riner must	11. Marital Status 12. Wes Decedent Ever in U. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	pecify Yes or No-	Race - American Indian,     Black, White, etc.
Maryland 21215-0020	urs a	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖾 No Specify:	1	Specify: white
15-0	ed within 72 hours ygiene. er than "natural", it, the Medical Ex. Completed by	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b. Kin	nd of Business/Industry
712	within iene.	Elementery/Secondary (0-12) College (1-4or 5+)	homemaker		her own home
0	a filed of Hygid		18. Mother's Nam	ne (First, Middle, Maiden S	
an			Doret	tta Schulze	
₹	d 2 should be the end Mente 7 is marked traumatic end To E	19a, Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rui		Town State Zin Code)
<b>S</b>	0 0 0 0				
Ġ,	F F F F	Douglas Thomas - Husband  20a. Method of Disposition 20b. P	18033 Putter Drive, H. lace of Disposition (Name of		laryland 21/40 cation - City or Town, State
פֿ	10 to 10 to	1 ☐ Burial 2 【XCremetion 3 ☐ Removal from State	emetery, cremetory or other place)	0/0/04	•
ij	t. Pag tment tant: f		gerstown Crematory	nage	erstown, Maryland
Baltimore,	permit. Pag Dapartment important: any injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility M:	innich Funer . Hagerstow	
		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	vec-c		Approximate
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Due to (o	r as e consequence of):	~	Interval Between Onset and Death
Box 68760,	auth certificate be assocuted attanding physician and for use as the burial-transit clary/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	as a consequence of):		
E	daath ne attar ed for u	Part II. Other significant conditions contributing to death but not resu	ilting in the underlying cause given in Part I.	23b. Did tobacco u	se contribute to the cause of death?
P.O.	nat tha daath ced by the attand latached for us.	Illnol loilere		1 □ Yes 2 □	No 3 Probably 4 Unknown
Division of Vital Records,	The lew requiras that tha daath cate hes been signed by the atta page 2 should be datached for Completed by Physicia	Hyper celcenia		24a. Wes an autops performed?	24b. Were autopsy findings available prior to completion of cause of death?
~	ifcian: The lew certificate hes rector, page 2 :			1LIYes 2P	o 1 ☐ Yes 2 ☐ No
E	entifica ector, a	25. Was case referred to medical	26. Place of Deat	h (Check only one)	
>	\$ 00	examiner?    Hospital: 1   Inpatient 2   1	ER/Outpatient 3☐ DOA Other: 4☐ Nursing Ho	ome 51 Mesidence 61	Other (Specify)
o uo	Attending Physical death.  Sector: After this by the funeral liftcation: 1			28d. Describe how injury	
Divis	tal or Attending P rs efter death. at Director: After t led in by the funer; Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of Injury - At ho building, etc. (Specify)	me, farm, street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	To the Hospital or Attending Phy within 24 hours effer death.  To the Funeral Director: After thi complataly filled in by the funeral  Medical Certification: 7		vledge, death occurred at the time, date and place, ion and/or investigation, in my opinion, death occurr	and due to the cause(s) and due to the cause(s) and perfect the time, date and p	nd manner as stated. llace, and due to the cause(s)
_	Nithin Fo the Somp		29c. License number	29d. Date	signed (Month, Day, Year)
		Lillar A	5 545 c 1 1 ac	(, , )	mber 8 7,114
	1	30. In address of person who completed cause of death (Item	23a) (Type Brint)	1 84 IL	14000
6	H	30. We and address of person who completed cause of death (Item	A IIIII medie	Com and	Rel
Ĭ	State	31. Date filed (Month Start Year) 0 2004 32. Registrar's Signat	urg Annals	1/	11.
	Registrar	Malur ,	v. por	Itale	Stown My

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			_	State of Marylar				•	_	ie.
			1 - State Registrar	•		rtificate o			Reg. No.	. 20000
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of De		'3. Time of Death
	Physici /Medic		Donald David	Walker,	Sr.		·	FREUST	30 ROOM	4 0300 M
	Examir		4a. Facility Name (If not institution, give		,	4b. City, Town	n, or Location of De	ath	4c. County of	
	Funeral		S. Social Security Number 6. Sec	Nedical CE	last birthday	If Under 1 Ye	150/4 ar   If Under 24 H			Omico Birthplace (State or Foreign
в	Funeral Director		324-30-8538	M 2□F	S7 Yrs.	Months Day	ys Hours M	n. (Month, Da	y, Year)	9. Birthplace (State or Foreign Country) Illinois
	pu >		Usual Residence of Decedent  10a, State 10b, County	100 C	ty, Town or Le					
	haryla shov	5								10d. Inside City Limits 1 X Yes 2 ☐ No
	the N	Director	Maryland Wicomico	Fr	uitland	10f. Zip Code	<del></del>		10g. Citizen of Wh	
	within 72 hours after death with the Maryland ane. than 'natural', or items 23a or 28a-f show he Medical Examiner must be notified at	io ie	403 Clardo Avonio			21826				
	ems 2	Funeral	403 Clyde Avenue	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of	of Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	USA 14. Race -	American Indian, White, etc.
36	s after , or Ite	by Fu	1 Never Married 2 Married	1 XYes 2 □ No Na If Yes, Give	vy	1 ☐ Yes <b>3</b> (☐ N		one moun, etc.,	Specify:	wille, etc.
5-0036	hours tural	ed b	3 ☐ Widowed 4 🔀 Divorced  15. Decedent's Edu	Year or Dates:					16b. Kind of Busi	White
215	nin 72 n "na Medic	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	(Give	kind of work do DO NOT use ret	cupation ne during most of v ired)	vorking	TOD. KING OF BUSI	nessindustry
21	filed with Hygiene. Ither than	E	10	Oollege (1-401 54)	Truc	k Drive	r		Steel I	industry
pu	be filed ital Hygi id other event, I	Be (	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	, Maiden Surname)	•
<u>Ş</u>	should to and Ment marked umatic e	ို	Harry L.	Walker	401.14		Helen			Unknown
Maryland	C/ C/ 20 00		19a. Informant's Name/Relationship (Ty Elizabeth M. Wilki		36				er, City or Town, St	
ē,	s 1 and F Health Item 27 other tr		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date	20c. Location - Ci	and 21826 ty or Town, State
E C	Pages lent of nt: If it		1 ☐ Burial 2 XCremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	-	matory or other p v. Cremat	1	+ 31, 2004	Salisbury	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.	6	2) Signature Funeral Service Licens	99	2					Association
<u> </u>	Per Imp		Jane of . Wo	mpson CF					bury, Mar	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dea ne cause on each line.	th. Do not en	ter the mode of o	tying, such as card	iac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	Teche	mec	Larg	Lampo	orth		mo
	Examiner		f	Due to (or as a conse	quence of):	,	CHY			
		je.	Sequentially list conditions, if any, leading to immediate	Due to for a la consec	quence of):	The contract of	- 4			- 7 ×
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Coro	man	the	Len	Duse		Jan Jan
760,	te be executed ysician and te burial-transit	EX	resulting in death) Last	Due to (or as a consec	quence of):					
	± × ±	dical		d			<u> </u>			
9 X	The law requires that the death certificate be exate has been signed by the attending physician bage 2 should be delached for use as the burial	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregn	ancy				23d. Date of	of delivory
Box.	death death	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of		Ectopic pregnal Other (specify)			Month	,
P.0	t the by the tache	hys	9 Unknown	9□ Unknown						
S, F	w requires that the deatt been signed by the atte should be detached for	by P	Part II. Other significant conditions con	ntributing to death but not re-	sulting in the u	nderlying cause	given in Part I.			ute to the cause of death?
Records,	requir een s nould	Completed						- 10	Yes 2□No 3	Probably 4 Unknown
3ec	The law sate has b page 2 st	npie						24a. Was autop	osv pric	re autopsy findings available or to completion of cause of
									2 X No 1 🗆	th?  Yes 2 □ No
Vital		o Be	25. Was case referred to medical examiner?  1 Yes 2 No	fospital: 2	ER/Outpatier	2 DOA		eath (Check only o	<i>nne)</i> dence 6 □Other	10
	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. In	jury at		now injury occurred	(Ѕресіту)
lor	Attending I r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(WOILII, Day 16al)	Injury		Vork? □ Yes 2 □ No			
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, sti	reet, factory, offic	<b>&gt;</b> 8	28f. Location (S City or Tox	Street and Number vn, State)	or Rural Route Number,
0	urs af urs af eral D		00.00.00	<u> </u>				1		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1X Certifying Physical Exemination (Check only one)	sicien: To the best of my kn ner: On the basis of examina and manner stated	ation and/or in	n occurred at the vestigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	////	Υ	29c. Lice	ense number		29d. Date signed (/	Month, Dey, Year)
			1 6/1	// // //	ク		20441		8/30/0	2004
A			30. Name and address of person who co			Print)				
\ <u>_</u>			1 50	eseph Rafter	Ho, M.O.	400 €.	Shore Dr.	salisbur	mo	· · · · · · · · · · · · · · · · · · ·
	Sta Registi		31. Date filed (Month, Day, Year) AUG 3 1 20	32. Redistrar's Sign	ajule /	spor	KN	J		

DHMH 17 Rev 1/2001

DONALD D. MAIKER 324-30-8538

		State Registrar	State of M	nary tarrar		cate of L		, , , , , , ,		g. No. () (	1 =	29890
	1	. Decedent's Name (First, Middle, Las	it)					1	2. Date of Dear	h Day	Yeer	3. Time of Death
cian dical	_	Minnie S. Ward							Month		04	3:15 PN
niner		a. Facility Name (If not institution, give	street and number	er)	4b.	City, Town, or	Location of	Death		4c. County	of Death	
		Atlantic General H				Berli		i Usa			Vorce	
al or		Social Security Number 6. Se	ex 7 □M 2[ <b>X</b> F	Age (In yrs. last I		Under 1 Year onths Days	If Under 24 Hours	Min.	3. Date of Birth (Month, Dey June 15	Year)	Coun	lece <i>(State or Foreigi</i> try) yland
		218-30-0829  Java Residence of Decedent		94		1			June 10	, 1010	Mai	yland
	1	0a. State 10b. County		10c. City, To	own or Location	n					1	0d. Inside City Limits
ctor	N	faryland Worcest	er	Berlin	1							1 ☐ Yes 2 🖾 No
Director	1	0e. Street and Number				Of. Zip Code			1	0g. Citizen of		itry?
ra		115 Flower Street,				21811		-0 (0	4. V N-	USA	te - Americ	en Indian
Funeral	! 1 i 1	1. Marital Status	12. Was Decede Armed Force 1 Tes 2	nt Everin U.S. ∌s? ™No	13. Was I	Decedent of His, specify Cuba	n, Mexican,	Puerto R	ican, etc.)		ck, White,	
by F		t ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1 🗆 Y	Yes 2□KNo	Specify:			Specif	Black	ζ.
ted	<u> </u>	15. Decedent's Ed		16	6a. Decedent's	s Usual Occupa	ation	né modrin	_	16b. Kind of B		
pie	-	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4)	or 5+)	life. DO N	of work done of NOT use retired	)	or working				
Completed		6th	140.		aborer					Privat		nily
Be (	1	17. Father's Name (First, Middle, Last)							First, Middle,			
ျှ	2	John Franklin						anor			Robins	
		19a. Informant's Name/Relationship (1			9b. Mailing Ad							Code)
	_	Eleanor Wilson/siste	<u>er                                    </u>	20b. Place	120 Flo	n (Name of		Ber		20c. Location		wn, State
1	1	1 XBurial 2 ☐ Cremation 3 ☐		ate !	etery, cremator			9/02	/200 <u>4</u> I	Rocomol	. M	aryland
	-	<ul> <li>4 □Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licenters</li> </ul>		St. Ja	mes Ch							sbury, MD
	1	A. T.	Block	lles		LEY M			222/23/21		Duii	21801
		23a. Part1. Enter the disease, or com	blication that cau	sed the death. [								Approximate Interval Between
ı	- 10	shock, or heart failure. List only Immediate Cause (Final	one cause on eac	h line.	1	1	I.	0				Onset and Death
	- 11	disease or condition resulting in death)	a. Due to (4)	as a consequence		27	fire	un	4		-	1 week
je	5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequent	ce of):							
Examiner		Cause (Disease or injury that initiated events resulting in death) Last	c									
EX	1	esuiting in obatin) Last	Due to (or	as a consequent	oe of):							
Cai			_ d									
10												property and the second
/Med	-	IF FEMALE:	23c. If yes, outco	me of pregnancy						23d Da	ite of delive	arv
cian/Med	- I WING	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal dea	ath 3□Ecto	opic pregnancy	,				ate of delive	ery Day Year
vsician/Med	yourdinme	23b. Was decedent pregnant	1 ☐ Live birtl	h 2 Fetal death at at time of death	ath 3□Ecto	opic pregnancy ner (specify)						*
v Physician/Med	y r nyarolalizate	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 Fetal death nt at time of death n	ath 3□Ecto n 5□Oth	ner (specify)			23e. Did to	М	onth	*
d by Physician/Med	a by ruyalciallimes	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 Fetal death nt at time of death n	ath 3□Ecto n 5□Oth	ner (specify)			23e. Did to	bacco use con	onth stribute to th	Day Year he cause of death?
sieted by Physician/Med	יובוכע הא רוואפונומוע שפיי	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 Fetal death nt at time of death n	ath 3□Ecto n 5□Oth	ner (specify)			1 □ Y	bacco use cones 2 DNo	onth	Day Year the cause of death? pably 4 Unknow
ompleted by Physician/Med	טוויףופוכט בא רוואפוטומוווואפע	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 Fetal death nt at time of death n	ath 3□Ecto n 5□Oth	ner (specify)			1 🗆 Y 24a. Was a autop	bacco use con es 2 DHo	onth  atribute to th  3 Prob  Were auto prior to coldeath?	he cause of death?  bably 4 Unknow  psy findings availab  mpletion of cause of
e Completed by Physician/Med	D D	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part IJ. Dther significant conditions of the conditions of	1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 Fetal death nt at time of death n	ath 3□Ecto n 5□Oth	ner (specify)	en in Part I.	of Death	1 🗆 Y 24a. Was a autop	bacco use con es 2500 (24b.	onth  atribute to th  3 Prob  Were auto prior to coldeath?	Day Year the cause of death? the cause of death? the cause of death?
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adical Cartification: To Be	edical Certification: To be	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Dther significant conditions of the past 12 months?  25. Was case referred to medical examiner? 1   Yes 2   No  27. Mann   Death 1   Natural   Death 1   Natural   Death   Dea	Hospital:  28a. Date of (Month, in the property)  28b. Place of building the property of the p	h 2 Fetal death at at time of death m  th but not resultin  patient 2 EPV  Injury  Day Yeer)  I Injury . At home  1, etc. (Specify)	ath 3 Ecto 5 Oth  Ig in the underl  /Outpatient 3 b. Time of Injury  In the underl  In the underl  Adde, death occ	her (specify)	en in Part I.  26. Place of the Part I.  9r: 4 Nursey at k?  Yes 2 Nursey at pinion, death	sing Hom	24a. Was a autopoperform of the Solution (Solution of Solution of	bacco use con es 2500  and 724b.	onth    3   Prob   Were auto   prior to coldeath?     1   Yes     ther (Specification of Rural of Rura	Day Year  the cause of death?  bably 4 □Unknow  posylindings available impletion of cause of  2 □ No  2 □ No  4 Houte Number,  tated.  to the cause(s)
adical Cartification: To Be	edical Certification: To be	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Dther significant conditions of the conditions	Hospital:  28a. Date of (Month, in the part)  28b. Place of building thysicien: To the barrier: On the bas	h 2 Fetal death at at time of death m  th but not resultin  patient 2 EPV  Injury  Day Yeer)  I Injury . At home  1, etc. (Specify)	ath 3 Ecto 5 Oth  Ig in the underl  /Outpatient 3 b. Time of Injury  In the underl  In the underl  Adde, death occ	tying cause given the time of time of	en in Part I.  26. Place of the Part I.  9r: 4 Nursey at k?  Yes 2 Nursey at pinion, death	sing Hom	24a. Was a autopoperform of the Solution (Solution of Solution of	bacco use con es 2 10 10 in es 2 10 in es 2 10 10 in es 2 10 10 in es 2 10 10 in es 2 10 10 in es 2	onth    3   Prob   Were auto   prior to coldeath?     1   Yes     ther (Specification of Rural of Rura	Day Year  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?
adical Cartification: To Be	Medical Certification: To be	23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Dther significant conditions of the conditions	Hospital:  28a. Date of (Month.)  28e. Place of building  hysicien: To the bas and manne	h 2 Fetal death at at time of death at time of death and the set of me at the but not resulting the but not re	ath 3 Ectc 5 Oth 5 Oth 1 Sign in the underly	tying cause given the factory, office curred at the tiringation, in my of the factory.	en in Part I.  26. Place of the Part I.  9r: 4 Nursey at k?  Yes 2 Nursey at pinion, death	sing Hom	24a. Was a autopoperform of the Solution (Solution of Solution of	bacco use con es 2 10 10 in es 2 10 in es 2 10 10 in es 2 10 10 in es 2 10 10 in es 2 10 10 in es 2	onth    3   Prob   Were auto   prior to coldeath?     1   Yes     ther (Specification of Rural of Rura	Day Year  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?  the cause of death?

			For State Registrar	State of Maryland		rtment of H			giene Reg. No. 2 () (	06 29891
			Decedent's Name (First, Middle, Last,					2. Date of Dea		3. Time of Death
	Physicia		MARION R	Willian	n 3			Month		04 4:56AM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	1	4c. County	
			ANL	honage		JA	1.5 hv	14	Wico	
	Funeral Director		5. Social Security Number 6. Se 10	7. Age (In yrs. la:	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	Peb. 1	1 9 1 2	9. Birthplace (State or Foreign Country) Maryland
	ס		Usual Residence of Decedent							10d Jacida City Limits
	urylar show		10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 Yes 2 No
	8a-f	cto	Maryland Somers	et M	arior				10g. Citizen of W	
	with th	ā	10e. Street and Number			10f. Zip Code 2183	0			
	s 23	erai	28148 Holland C:	12. Was Decedent Ever in U.S		Vas Decedent of Hi		pecify Yes or No-	U.S.	A - American Indian,
	her de	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	11	Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Blaci	k, White, etc.
2	ors a	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	Black
2	72 ho	Completed by	15. Decedent's Edu (Specify only highest grad		(Give	ient's Usual Occupa	during most of wor	rking	16b. Kind of Bu	siness/Industry
2	within lene. then	npi	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	)		None	
2	iled within 72 hours after death with the Maryland Hygiene. other then "naturel", or Items 23a or 28a-f show ont, I'ra Medical Examiraer must be notified at	CO	17. Father's Name (First, Middle, Last)		ווסמ	nestic	18. Mother's Nar	ne (First, Middle,		e)
and	ould be fi Mental H arked ot atic ever	Be	LLoyd Dennis					Whitti		-,
Š	should ind Men s marke umatic	은	19a. Informant's Name/Relationship (T	rpe, Print)	19b. Mailin	g Address (Street a				State, Zip Code)
<u>8</u>	od 2 sho Ith and 27 is m		William Handy (		28148	Hollan	d Cross	sing Rd	.Mario	n,Md.21838
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or items 23a or 28a-1 ahow any njury or other traumatic event, the Madical Examinat must be notified at ODEs.		20a. Method of Disposition	20b. Pla		sition (Name of natory or other place		Date		City or Town, State
E C	Pages ent of nt: If i		1 Burial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,	temoval from State		ley Cem		-04	Marion	Md.
a E	mit.		21. Signature of Funeral Service Licens			Name and Address		Home		
Õ	Deparent Dep		Gladys B.	Stewart	82	1 West	Rd.Sal:	isbury,		01
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. ne cause on each line.	. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	ASCVD						Oriset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque		2 4	, ,	1		
	LAGITITICI	_	Sequentially list conditions,	b. Chronic  Due to (or as a consequence)	ence of):	Renal Mell	fai	INTE		
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Diabet	20 6	Moll	itua	,		
_6	be executed sician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a consequence	ence of):	1 ( )		>		
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai E		d						
9	ificati g phy as the	ledic								
Вох	eath certific attending p	N/US	23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregnancy	,			e of delivery
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐ Pregnant at time of de 9☐ Unknown		Other (specify)			Mor	nth Day Year
P.0	at the de i by the stached	Physician/Me	9 Unknown		Main and the second		in Dod I	220 Did to	phases use contr	ribute to the causa of death?
	ires tha signed I be del	þ	Part II. Other significant conditions co	intributing to death but not resu	liting in the u	nderlying cause giv	en in Parti.			3 Probably 4 Anknown
Records,	w requir been s should	Completed						100		
§ec	elaw hast e2s	å j						24a. Was autor perfo	osy p	Vere autopsy findings available or prior to completion of cause of death?
a F								1 ☐ Yes	200 No 1	☐Yes 2☐No
Vital		o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ 8	ER/Outpatier	nt 3 DOA Oth		ath (Check only of Home 5 - Resid		or (Specify)
of		$\vdash$	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at	_	now injury occurre	
Division	or Attending I ifter death. Director: After in by the funer	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1 🗆	K? Yes 2 □ No			
Vis	f or Attendiater death.  Director: A	ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (3	Street end Numbe	er or Rural Route Number,
ā	tal or Att	Certification:		Sandary, Sto. (Opolity)	·			, , ,		
	To the Hospital within 24 hours a To the Funeral Completely filled		(Check only 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinati						
	To the H within 24 To the F complete	Medical	one)	and manner stated.		29c. Licens				1 (Month, Day, Year)
	vition Co	-	29b. Signature and title of certifier	λ		0 5	795	9	9/4/	04
	_		Tolker 19.	completed cause of death (the	23a\ /T	Print)	, 100		1/7/	/
D	6		Babulal was	completed cause of death (Item	23a) (Type,	ulford	ST. #.	504B.	Salesbu	m. MD2180/4
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat		low	,			
		17	SEP 0.7.200	A. Len		awaren				

			For State	State of Maryl		artment of H			00	0.1	25220
			Registrar  1. Decedent's Name (First, Middle, La	ct)		Tillicate of i	Jeani	2. Date of Death	g. No.	1111	3. Time of Death
	Physicia	an	_		*** 1 1			Month Septembe	Day	Year	6:50 a.m.
3	/Medic	_	Betty  4a. Fecility Name (If not institution, given	Armentrout	WILL	iams 4b. City. Town, or	Location of Dea		4c. Count		0.30 a.m.
	Examin	er			or	, , , , , ,	nardtown		St	. Mar	v 's
,	Funeral			Nursing Cent	e I vrs. last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth			lece (State or Foreign
	Director		220-12-3906	I□M 2@F 7	8 Yrs.	Months Days	Hours Mir	Feb. 26	,1926	Mary	
	pt ,		Usuel Residence of Decedent	100	. City, Town or L	agation				110	0d. Inside City Limits
	aryla ahov	_	10a. State 10b. County		. City, TOWN OF L					"	1 ☐ Yes 2 ☑ No
	28a-1	ecto	Maryland St. Man	y's		Califo	ornia	16	g. Citizen of	What Coun	trv?
	with t	Funeral Director			- J	206	1 0		United		•
	eath ma 23	eral	24169 North Patuz	12. Was Decedent Ever		Was Decedent of H			14. Ra	ce - Americ	an Indian,
10	r Iten	Fun	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗑 No				rto Rican, etc.)		ck, White,	
99	hours after death with the Maryland ture!; or Itema 23e or 28e-f show at Exeminer must be modified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ₺ No	Specify:		Speci	y: Whi	се 
9	n 72 hours after death with the Marylan "natural", or Itema 23a or 28a-1 show kolical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr		(Give	edent's Usual Occup	during most of w	orking 1	6b. Kind of E	Business/Ind	lustry
21	d within giene. ir than "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		0		_
2	77 77 -		12 17. Father's Name (First, Middle, Las	4		Homemake		ame (First, Middle, N		n Hom	e
and	be de la se	Be						Elizabeth			
Ž	2 ≥ 2 2	ဥ	Russell Hull Arme		19b. Mail	ing Address (Street		Rural Route Number,	_		Code) 20 C 1 O
Maryland 21215-0036	nd 2 she lith and 27 is m traum		Bernard A. Willia					Beach Roa			
_	Hea Hea the	1 3	20a. Method of Disposition		b. Place of Disp	osition (Name of omatory or other place	1	and the same of th	Oc. Location		
no	0 0 = -		1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special Control of Con	Removal from State	•	ld-Echols		.3, 2004 C	harlot	te Ha	11. MD
Baltimore,	- 문문분	1	21. Signature of Fundal Service Lice					insfield			
B	Depa Impo any ir		Mary Ricald	K1270 MO11							20650-0279
160			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	plications that caused the	death. Do not en	iter the mode of dyin	ig, such as ardi	ac or respiratory arre	st,		Approximate interval Between
1	Physician	8 1	Immediate Cause (Final	R .	NAM	atory t	milles	21 -		^	Ornset and Death
1	/Medical		disease or condition resulting in death)	a.  Due to (or as a con	sequence et):	JAKA.	3	00	7	, //	inmers
	Examiner		Compostially list conditions	b	soma	DXHON	welles;	ulmorere	112		years
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sequence of):					- (	
	ecute ind trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c							
90,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-transit	Ē	1050iting in dodiny cast	Due to (or as a cor	isequence or):						
8760	physic physic the b	dicai	•	d							
9 ×	eath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pro	egnancy				22d D	ate of delive	
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	1				Day Year
o.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	or doubt of						
0	es that the		Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use cor	tribute to th	ne cause of death?
ds	uires sign ld be	d by						1 □ Ye	s 2 🗆 No	3 🗍 Prob	ably 4  Unknown
ecords,	w requir been si should	Completed						24a. Was an	1 24b.	Were autor	psy findings available
Re	he lav e has	m C						autopsy	red?	prior to con death? 1 \( \text{Yes} \)	inpletion of cause of
Vital	ician: Th certificate rector, pag		25. Was case referred to medical				26. Place of D	1 ☐ Yes 2 eath (Check only one	No	1 1 1 1 1 1 1 1	2 140
>	ding Physician: The In. After this certificate ha funeral director, page	o Be	examiner? 1 ☐ Yes 2 1 No	Hospital:	2 ER/Outpatie	ent 3 DOA Oth	or -	Home 5 ☐ Reside		her (Specify	1)
Jo I	ding Phys	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time (	of 28c. Injur War	y at	28d. Describe ho	w injury occu	rred	
Division		Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	on	.,,		Yes 2 □ No				
N S	er de recto	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			treet, factory, office	1.00	28f. Location (Str. City or Town		ber or Rura	l Route Number,
Ō	rs after al Direction by	Ce						ļ			
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	icai	(Check only 2 Medical Exe	hysicien: To the best of my miner: On the basis of exa							
	tha hin 2. the f	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	20	d. Date sign	ad (Month I	Day Year)
	To To	-	29b. Signature and title of certifier	Allen lors	-11.	1 7	6011	9	9-1	01	_
	P		1 NOVIVE	1 XWWO <	THE	JOU C	TUTI		1 of	-07	7
	5		30. Name and address of person wh	1/			r_11 L_	1 mreed 16	a-w1 -		2.6
_		ate	J. Patrick Jarbe	De, M.D., 240	ignature (	= NOECH K	Jan, nol	тумоод, М	агутап	u 200.	00

Wright Bertha\_

Baltimore, Maryland 21215-0036

A SECTION ASSESSMENT	
Division of Vital Records, P.O. Box 68760,	

				Type or Print in Black In State of Maryland / Depa			
			1 - For State Registrar	Ce	rtificate of Death		Pg. No. 004 29893
	Physic /Medi		1. Decedent's Name (First, Middle, Las Bertha M. Wrig	nt		2. Date of Death Month	Day Year
	Examii	ner	4a. Facility Name (If not institution, give Doctor's Hospital		4b. City, Town, or Location of Lanham, MD	of Death	4c. County of Death Prince George's
	Funeral Director		211-32-7402	7. Age (In yrs. last birthday)  M 2 X F 66 Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. Date of Birth Min. 05-23-19	9. Birthplace (State or Foreign Country) LaGrange, NC
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Prince Georg	ge's Oxon Hill	ocation		10d. Inside City Limits 1X Yes 2 □ No
	3a or 28	i Direc	10e. Street and Number 810 Forest Drive Sou	th	10f. Zip Code 20745		Og. Citizen of What Country?
036	ours after death rel', or items 2 Everdiner mu	by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No	Mas Decedent of Hispanic Orion     Yes, specify Cuban, Mexican     □ Yes 2    No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23s or 28s-f show other traumatic svent, it a Medical Evantinat must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	(Give	dent's Usual Occupation kind of work done during mosi DO NOT use retired) CUREMENT	t of working	6b. Kind of Business/Industry  D.C. Covernment
Maryland	ould be fil Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) Frank Revis			r's Name <i>(First, Middle, M</i> tha Kennedy	faiden Sumame)
	1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (T) Robert L. Wright/husba		ng Address (Street and Numbe prest Drive South		City or Town, State, Zip Code) 20745
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify, 21. Signature) of Funeral Service Licens	Riverdale F	ark Crematory 0	9-07-2004 F	Oc. Location - City or Town, State  Riverdale, MD
Ba	permit. Departr Importe any Inju		Expone		Name and Address of Facility Tyrone J. Young 719 Kennedy St		
	Physician /Medical Examiner  cian and cian and mial-transit	ıl Examiner	shock or pear failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Myocardi. Heart F		
.O. Box 68760	that the death certificate be exed by the attending physician detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	:3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	se un eg	by	Part II. Other significant conditions co	ntributing to death but not resulting in the ur	derlying cause given in Part I.		accoluse contribute to the cause of death?
	The law ate has b page 2 sl	e Completed	25. Was case referred to medical			24a. Was an autopsy performe	
01	S S	To B	examiner? 1 Yes 2 No	fospital: 1   Inpatient 2   ER/Outpatient	30000A Other: 4□ Nur.	of Death (Check only one) sing Home 5 \sum Resident	ce 6 ☐Other (Specify)
DIVISION (	ittending death. ctor: After / the fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Place of Injury - At home, farm, stre	28c. Injury at Work?  M 1 Yes 2 N		
=	pitel or A burs after erel Direr		4 Homicide determined	building, etc. (Specify)		City or Town,	,
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	one)	sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	estigation, in my opinion, death	n occurred at the time, date	and place, and due to the cause(s)
t	S of M of	-	29b. Signature and title of certifier	and manner stated.  M   D   mpleted cause of death (Item 23a) (Type, F	mph (a)	545 S	Date signed (Month, Oay, Year)  2004
C.A	2(5)		30. Name and a less of person o co	mpleted cause of death (Item 23a) (Type, F	ohan mi	D 20706	
	Sta Registr		31. Date filed (Month, Day, Year) SFP 0 7 2004	. Registrar's Sign ture	w.		
DHN	IH 17 Rev 1/20	001	OLI VI	1			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30 AM /Medical 4c. County of Death acility Name (It not institution, give street and number) 4b. City, Town, or Location of Death H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day. **Examiner** 301 -101 Birthplace (State or Foreign Country) last birthday) 5. Social Security Number 6. Sex 7. Age (In yrs. **Funeral** 1 🗆 M 220-60-0 ItalyDirector Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahov rry or other traumatic avant, Ite Marylcal Exporter must be retilified at 1 XYes 2 No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 301 Burnside Street A101 21403 United States Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2XXNo White Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ring most of working Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmelina Ferrara Ettore Polizzi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William White Husband 301 Burnside Street Apt: A101 Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or o once. 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State Baltimore Crematory 9/1/2004 Baltimore, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility permit. Depart John M. Taylor Funeral Home, Inc MD 21401 147 Duke of Gloucester St Annapolis, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) 5 month Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner t or Attending Physician: The law requires that the death certificate be executed after death. physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has 1 Yes àØ No 86 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: Hospital: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / d in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier, 29c. License numbe 29d. Date signed (Month. Day, Year) cause of death (Item 23a) (Type, Print) person who completed HOR TON 31. Date filed (Month, Day, Year) SEP 0 2 2004 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene [ ] [ ] 29895 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) August 29, 2004 ear **Physician** 6:55 A Young Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Charles Waldorf 404 Trefoil Place | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | October 31, 1954 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days **X**OXM 2□ F Yrs. Maryland 49 Director 217-60-6382 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23e or 28a-f show any Injury or other traumatic event. It a Medical Examinating the puffled at ORE. XXYes 2 No Waldorf Maryland Charles Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20601 404 Trefoil Place Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give XX Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pyles Lumber Company Operator 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be V. Dennis Mary Dotson W Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Trefoil Place Waldorf, Maryland 20601 Margaret Young/Wife 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 20a. Method of Disposition Clinton, Maryland 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 9/2/04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home P.A. Aquasco, Maryland Dessa MO1323 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Necla Cancer Head and Pnysician /Medical Due to (or as a consequence of) p4 Cal ce unic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit the mia Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0053219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TE POST Office Road, WALDORF, MD 20602 ANSARI MD 31. Date filed (Month, Day, Year) SEP 0 State 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 17, 2004 September 11:40 AM David Lewis Anderson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care Nursing Center Wheaton 8. Date of Birth (Month, Day, Year)
Jan. 21, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Days Yrs 1926 Director 114-16-7931 78 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 20906 12716 Saddlebrook Dr. United States items 23a Pages 1 and 2 should be filed within 72 hours after death Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes XXNo Specify: Specify: Black 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+Administration Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F Anderson 0ra Lewis James Taylor ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20906 Nancy I. Anderson / Wife 12716 Saddlebrook Dr., Silver Spring, MD item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 21 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H important: If ite any injury or ot once. 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Beltsville, MD Chesapeake Crematory 22. Name and Address of Facility
Rapp Funeral and Cremation Services 21. Signature of Funeral Service Licensee Steple Dohmann Mov 382 20910 933 Gist Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Metastatic Cancer years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Prostate Cancer years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes XX No certificate Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4XXNursing Home 2 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Alter 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 2 September 20, 2004 D32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #220 Suresh K. Gupta, 9801 Georgia Ave., Silver Spring, MD 20902

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 2 2004

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 18, 2004 5:45 P.M Mary Armstrong Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1130 Price Station Price Queen Annes 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2₹ F Months Days Hours 213 36 0774 65 Director 26, 1939 Jan. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Maryland Queen Annes Centerville 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 121 Coon Box Road 21617 U.S. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White ۾ 3 X Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) of Health and Mental Hygiene. College (1-4or 5+) MD. Rehab. Patient Driver State of Maryland 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Charles William Armstrong Mary Anna Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Snowden / daughter P.O. Box 421 Centerville, Maryland 21617 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or ot 2002. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 9/21/2004 Baltimore, Maryland 21. Signatura of Fundral Service Licen 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause prisase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. | the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 🗆 No 3 Probably 4 □Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' certificate 1 Tes 2 TNo funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Sons Home 1 🗌 Yes 2 No 1 🗌 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 0 3 Alegistrar's Signature 31. Date filed (Month, Day, Year) State 2 2 2004 Registrar

		1 - For State Registrar	State of Maryla		artment of rtificate of		Mental H		~ ~ ~	5
Physic	ian	Decedent's Name (First, Middle, La	st)			A	2. Date of D Month	Day	/ Year	3: Time of Death
/Med Exami Funeral		4a. Fecility Name (If not institution, given the Johns 15. Social Social Number 1660 6.5	OPKINS HO	Ospital last birthday)			S. 8. Date of B	√ 4c.	County of Death  9. Birthr	0729 M
Director		390-38-4660 Usual Residence of Decedent  10a. State 10b. County	XXM 2□F 69	Yrs.		S Flours Will	2/27/1	935	WIS	CONSIN
the Marylan 28a-f show	Director	WI BARR		RICE L	AKE					N Y Yes 2 No
th with 23e or	ai Dir	939 LAKESHORE D	RIVE		10f. Zip Code 548				zen of What Cour JSA	ntry'?
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23s or 28s-f show event, it a Medical Exerting must be notified.	by Funeral	11. Marital Status  1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cu 1 ☐ Yes ※XXN	Hispanic Origin? ( ban, Mexican, Pue o <i>Specify:</i>	Specify Yes or N rto Rican, etc.)		14. Race - Americ Black, White, Specify: WH	etc.
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a la b	To Be Co	12 17. Father's Name (First, Middle, Last, HIRAM AVERY		SEI	LF EMPLO	18. Mother's Na	nme (First, Middle	e, Maiden	BBY/TRAIN	N SHOP
nd 2 sulth ac 27 is r trau	-	19a. Informant's Name/Relationship (	Type, Print)			RE DRIVE	lural Route Numi	ber, City or		
Heg Hem othe		20a. Method of Disposition  1 X Yurial 2 Cremation 3X  4 Donation 5 Other (Specif	Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other pl	ace)	Date Unk	20c. Lo	cation - City or To	wn, Stete
permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Licer KELLY FREGORA	FINK MO1148	22	Name and Add	ress of Facility F	NK FUNE	RAL H EN BU	IOME, PA URNIE, MI	21061
death certificate be executed  American Parameter of the burial-transit of for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quence of):	nfarchie		o or respiratory a	11651,		Approximate Interval Between Onset and Death
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 🗆	Ectopic pregnand Other (specify)	су		2	3d. Date of delive Month	ry Day Year
w requires that the been signed by th should be detache	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the un	derlying cause g	iven in Part I.				e cause of death? ably 4 Unknown
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ding h. After fune		27. Manner of Death  1  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe			)
in Direct	Certification:	3 Suicide 6 Could not be determined	building, etc. (Speci	<i>ħ</i> y)			City or To	wn, State)	Number or Rural	
FL A P	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	ysician: To the best of my kni niner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occu	a, and due to the urred at the time,	cause(s) a date and p	and manner as sta place, and due to	ated. the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	0			se number			signed (Month, E	
10		30. Name and address of person who Rinky Bhata	completed cause of death (ite	ospital	Print)					
Sta Regist		SEP 2 2 200	32. Registrar's Sign	ature	200					

ROY M BEATTY 04-5799 DAP

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of H <i>rtificate of</i>		, ,	giene Reg. No?	16 20000
Physici /Medic		Decedent's Name (First, Middle, Last Roy M. Bea					2. Date of Dea Month SEPTEME	ath	Year 004 8:24a
Examir		4a. Facility Name (If not institution, give MERCY HOSPITAL				MORE CI	TY	4c. County	of Death
Funeral Director		5. Social Security Number 6. Security Number 216-50-1088	x 7. ]M 2□F	Age (In yrs. last birthday, 56 Yrs.	If Under 1 Year Months Days	Hours M	Mar 28,	1948	9. Birthplace (State or Forei Country) Washington DC
Maryland a-f show ified at	tor	10a. State 10b. County MD Baltim	ore	10c. City, Town or L Ba1	cation timore				10d. Inside City Limi 1 ☐ Yes 25 N
h with the	Funeral Director	10e. Street and Number 1143 B Courtney R	oad		10f. Zip Code	227		10g. Citizen of V US	-
within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f show ha Madical Eraminar must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 📆 Divorced	12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	os? DNo	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☑ No	dispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)		e - American Indian, k, White, etc.
d within 72 hardiene.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-40	or 5+) (Give	dent's Usual Occup kind of work done DO NOT use retire Cic equip	during most of ( d)		16b. Kind of Bu	siness/Industry
2 should be filed withir and Mental Hygiene. Is marked other than sumatic event, the M	To Be C	17. Father's Name (First, Middle, Last)  Roy Rhode				18. Mother's N	<sub>Name (First, Middle,</sub> arise Beat	Maiden Sumam tty	θ)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygener. Department of Health and Mental Hygener. Important: If Item 27 Is marked other than "natural, or Items 23s or 28s-f show any injury or other traumatic event, the Madical Examinat must be notified at once.		19a. Informant's Name/Relationship (T) Scott Sewell/broth  20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☒ Donation 5 ☐ Other (Specify)	er	1707 20b. Place of Disp	Anne Ave	enue Bal	Rural Route Numbe	ID 2122	_
permit. P Departme Importar any injur		21. Signate of Funeral Service Licens	99 1		2. Name and Addre cate Anato Itimore,		rd 655 W.	Baltimo	ore Street
Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequence of):					Approximate Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai	resulting in death) Last  IF FEMALE:	d	as a consequence of):					
at the death certific by the attending p tached for use as i	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)	/		23d. Date Mor	e of delivery ith Day Year
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Phys this ral dir	ion; To B	27. Manner of Death  1 Natural 5 Pending	1 Inpa 28a. Date of In (Month, I		f 28c. Injur	er: 4 □ Nursing	Home 5 ☐ Reside	ence 6 Othe	
Atten er deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At home, farm, str etc. (Specify)		163 2 110	28f. Location (St City or Town		or or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phy:  X Medical Exami	sician: To the be ner: On the basis and manner	st of my knowledge, deat s of examination and/or in stated.	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the courred at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
To t To t	X	29b. Signature and title of certifier			29c. Licens	e number		_	(Month, Day, Year) ER 9, 2004
		30. Name and address of person who co							

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ROY **AMOS** BRADLEY blember 16 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospita Rosedale Baltimore Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5-11-1934 Social Security Number 9. Birthplace (State or Foreign **Funeral** 215-30-1896 X M 2□F Months Days Hours Min 70 Yrs. MARYLAND Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10a, State 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatih and Mental Hygiene. snt: If item 27 is marked other then "naturel", or Items 23a or 28a-1 shov ury or other treumatic event, I're Medical Exa inter must be notified at MD BALTIMORE 1 ☐ Yes 2 No Director ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8103 PHILADELPHIA ROAD 21237 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ŽŽXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 🎇 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) BRADLEY HOME Elementary/Secondary (0-12) College (1-4or 5+) BRICK MASON IMPROVEMENT 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELDON BRADLEY MILDRED (HIGGS) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent; if item 27 is eny injury or other treu QDCs. ROY BRADLEY, JR./ SON 7419 NORTH POINT ROAD BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State METRO CREMATORY 9-21-2004 CATONSVILLE, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final o Cardia Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 \( \subseteq \text{Yes} \quad 2 \subsete \text{No} \) Day Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 25 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records,

hours after death. within 24 hours after deati To the Funerel Director:

State

Registrar

29b. Signature and title of certific

investigation

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who co leted ause of death (Item 23a) (Type, Print)

Franklin Square

31. Date filed (Month, Day, Year) SEP 2 2 2004

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 | Homicide

37 Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy E. Burns 9:24PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Rusedale vanKlin Mare If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 □ M 2 □ F Director Yrs. 220-03-3596 Oct. 11, 1918 <u>Maryland</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Md. Harford Director Bel Air 1 ☐ Yes 2 € No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1146 Sparrow Mill Way 21015 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permin. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Importent: if lem 27 is marked other then "naturel" or he any injury or other traumation. 1 Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Completed by 3 ☐Widowed 4 ☐ Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 12 years homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving Clay Hopkins Lucy Estelle Coale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ferguson 1146 Sparrow Mill Way, Bel Air, Md. 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Holly Hill Mem. Gdns. 9/20/2004 ' 4 ☐ Donation 5 ☐ Other (Specify) Middle River, Md. 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Immediate Cause (Final Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of) eart disease. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause power in Part I. 23e. Did tobacco use contribute to the cause of death Records, by 1 ☐ Yes 2 ☐ No 3 Probably Completed certificate has b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Vital 2 No 2□ No 1 ☐ Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Impatient 2 ER/Outpatient this 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: in 24 hour.
The Funeral Directory filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29b. Signature and Atle of ce 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) Shi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 2 2004 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year September 15 2004 21:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BAItimoze
Vaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hospital The Johns Hopkins
5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 M 2□F 360 214-86-9769 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Examiner must be rigitized at 1 Yes 2 No MD Daltimore Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BI 7204 21208 USA DR stone Pages 1 and 2 should be filed within 72 hours after death vient of Health and Mental Hygiene.
and: If item 27 is marked other than "natural", or Items 23a and viry or other treumetic event, it as Madical Examination in the Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced lac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANsportation 11-4 12000 RIVER N 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brown Albert vonne Watson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - Mother 7204 Chalkstone DR. Apt. BI Balto MD 21208 vonce Mallory 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04 \* 4 □ Donation 9-20venatory! O 21. Signature Juneral Service Licensee 22. Name and Address of Ficility march F. H. West 21215 4300 Wabash Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval etw nglediate Cause (Final Physician nease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine inding physician and use as the burlal-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last to or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown s been signed by should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cept 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month SE

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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Olomb

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 2034 **Physician** Pearl C. Berigtold /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death **Examiner** St. Agnes 5. Social Security Number Healthcare Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-34-2584 1 □ M 2√□ F 90 Yrs. Sept. 12, Director 1914 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ?7 is marked other than "neturel", or items 236 or 28a-f shov treumatic event, the Medical Exame activitistics to a cutified at Baltimore 1 X Yes 2 □ No Maryland Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 Benson Ave. Apt. G31 21227 U. S. A. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: iit. Pages 1 and 2 should be filed within 72 hours after aftern of Health and Mental Hygiene.
rient: If item 27 is marked other than "neturel, or Ite mary or other treumatic event, Its Neutschie Exuria. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ₩Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Manufactoring of Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker slip covers 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert A. Weidner, Sr. Estella Ball 19a. Informant's Name/Relationship (Type, Print)
Mary C. Noetzel, daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3137 Ryerson Cir. Lansdowne, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Lakeview Memorial Park 09-22-04 Sykesville, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licenses Ambrose runeral Home of Lansdowne Depar impor any r repres 2719 Hammonds Ferry Rd. Sykesville, MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical quence of): Due to for as a cons Examiner MONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{Yes} \quad 2 \)
No Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 certificate Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□Yes 2€No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral dir this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 2-Natural Division 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel or 24 hours 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Func

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and preprint stated. (Check only one) 29b. Signature and title of certifi 30. Name and address of pers, who completed cause of death (Item 23a) (Type, Print) Choice Case und 21228 State 32 Regista's Sight State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L Amend item # 9,11-12,15,16a-b,1/-18,19a-b,20a-c,22,per FH C835.9 State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar 29901 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Brown 8:07 AN 4a. Facility Name (Iffnot institution, give street and number) September 11 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKins Hospital Baltimore Johns If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 7, 1957 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Min. 1**∑**M 2□F Hours unk MD 213-80-8744 46 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1√ Yes 2 No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1211 N. Chester Street 21213 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. unk 1 Never Married 2 Married unkBaltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: Specify: black þ 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry 15. Decedent's Education <del>unk</del> (Specify only highest grade completed) d 2 should be filed within 7 h and Mental Hygiene.
7 Is marked other then \*n Elementary/Secondary (0-12) College (1-4or 5+) Unemployed N/A unk unk G.E.D. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be Willis Brown, Jr. Mattie Stokes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is in any injury or other traum <u>once</u>. Mattie Dennis/ Mother 1139 Glendale Rd. Apt K, Balto.', MD 21239 20b. Place of Disposition (Name of cem place) 20c. Location - City or Town, State 20a. Method of Disposition 9/28/04 Dundalk, MD ■ Burial 2 Cremation 3 Removal from State `4 □Donation 5 ₩Other (Specify) in state 22. Name and Address of Facility March F.H East, 1101 E. North Ave 21. Signature of Euneral Service Licensee Director Board 655 W. Baltimore Storet 21201 Baltimore, MD 21202 Baltimore, MD nun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) intection Physician JImenacy /Medical Due to (or as a cons quence of): **Examiner** immune det Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit tailure Liver the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an interest myocardia certificate has autopsy performed 2 X No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Certification: To this is 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 SNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 Officer RES-000 September 11,2004 Housestatf 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21287 N. Wolfe bewin Leslie 600 32 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 2 2 2004 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2000 Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** Regis Robert Boyle September 20, 2004 1:50P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11455 Oak Leaf Drive Montgomery Silver Spring 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 2, 1 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Yrs. 60 Director 1944 Pennsylvania 168-34-5402 Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Modeal Examiner must be notified at 1 ☐ Yes 2 ☑ No **Funeral Director** Silver Spring Maryland| Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11455 Oak Leaf Drive 20901 death v United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 le marked other than "natural", or Item any injury or other traumatic event, the Midfall Examilient Once. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by 3 □ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evelyn M. Bailey ဂ Joseph H. Boyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Grandin/Daughter 3 Basildon Circle, Rockville, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. 2004 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service License . моовоз 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 6 Years Multiple Myeloma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the à signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has to page 2 s nnea≀ 2**X** No certificate 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) P 1 ☐ Yes 2X No this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide hours after within 24 hours at To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20542 September 21, 2004 30. Na e and add ss of person who completed cause of death (Item 23a) (Type, Print) 10 Joseph P. Catlett, M.D. 110 Irving Street, N.W., Washington, D.C. 31. Date filed (Month Pay 2 2 2004 32. Figistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registramend ITEM #7 PER FH C835 9/22 Polificate of Death 2. Date of Death 3. Time of Death Month Physician Secker 1232PM Benjamin /Medical 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c County of Death Examiner RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth AUG. 27, 1916 Birthplace (State or Foreign Country) **Funeral** 1 ▼M 2 □ F MD 82 88 215-18-7876 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f show or other traumatic event, it e Madical Exacticat must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director RANDALLSTOWN BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21133 3801 SCHNAPER DRIVE #401 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after XYes 2 □ No Yes, Give Year or Dates: 1 ☐ Never Married 2 🛣 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOBILE SHOP OWNER other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any july or other traumatic event once. Be **BECKER** LEVER GOLDIE SAMUEL. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 WOODHOLME VILLAGE COURT - PIKESVILLE, MD 21208 GLORIA FRANK / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/20/2004 DUNDALK, MD WORKMEN CIRCLE CEM. \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) o the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the burial To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 \ No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Menth, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification; After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

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State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

WD

32 Registral's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

SEP 2 2 2004

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item #10a-c 10e-f. per Inf. C836.10:12:04 TT

State of Maryland / Department of Health and Mental Hygiene

		1	Amend item #10a-c 10e-f.per State of Maryland	Tof G	3836,10;1 intment of F tificate of	Tealth a	and Mental Hy	7.4	0.1	000	0 7
			Registrar  1. Decedent's Name (First, Middle, Last)		inicate of	Death	2. Date of De	Reg. No.		-3. Time of	Death
	Physicia		Thomas James Conroy				Month	Day	Year	6:27	Рм
	/Medic	al	•		4b. City, Town, o	or Location	Septem Septem		, 2004 inty of Death		_
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			Johns Hopkins Bayview Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. las	t birthday)	If Under 1 Year		24 Hrs. 8. Date of Bi	th	9. Birth	place (State	or Foreign
	Funeral		5. Social Security Number 6. Sex 1 № M 2 □ F 7. Age (In yrs. las	Yrs.	Months Days	Hours	24 Hrs. 8. Date of Bir Min. (Month, Date of April 3	iy, Year)	Penn	<sub>intry)</sub> sylvan	nia
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	286 1	rec	10e. Street and Number		10f. Zip Code	20		10g. Citizen	of What Cou	intry?	
	Mit a		1120 Hammacher Avenue Southwest	<u> </u>	3290	18		USZ	A		
	be fled within 72 hours after death with the Maryland at Hygiene. All Hygiene. do dother than 'natural', or items 23a or 28e-f show event, the Madical Exemiter mast be nullified at event, the Madical Exemiter mast be nullified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of I	Hispanic Or	igin? (Specify Yes or No.)		Race - Ameri Black, White,		
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2	and salth n 27 sertr		Patricia Ann Conroy (Wife)		osition (Name of	Averi	Date		ion - City or T		
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банттог	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic evonce.		21. Signature of Funeral Service Licensee	22	2. Name and Addr Bruzdzin	ess of Facil Ski Fl	ineral Home	P.A.	State of the state	31	1001
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	/Medical Examiner		resulting in death)  Due to (or as a consequence)	ence of):							
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Division of Vital	of or Attendate after death I Director: /	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At homicide 28e. Place of Injury - At homicide building, etc. (Specify	)	treet, ractory, orno	ð		own, State)			
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	thin 2 thin 2 the mptel	Med	29b. Signature and title of certifier		29c. Lice	nse numbe	r	29d. Date s	signed (Monti	h. Day, Year,	)
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	17		30. Name and address of person who completed cause of death (Item	EAS	TERN	BL	ND - A	1 D -	2/2	21.	
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signal								
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DHMH 17 Rev 1/2001

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Itimore, Maryland 21215-0036	ges 1 and 2 should t of Health and Mer if Item 27 is marke or other traumatic		Sara Vallejo ( 20a. Method of Disposition	Daughter)	lace of Dispo	Twilig		Date	20c. Location - City or	Town, State
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			shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.						Onset and Death
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	~	,	Kubelle l	- n		0.5	6705		September	19th, 2004
	r	1	30. Name and address of person who co	mpleted cause of death (Iter	п 23а) (Туре,	Print)				
_	U		michell Committee		topkir	s Bayı	view Circ	le Ba	Himore M	021224
	Sta	ate	31. Date filed (Month, Day, Year)	32. Register's Signa	ature &	South)		/		

			For State		•				nd Mental H		100	00000
			1 - State Registrar AMEND ITF  1. Decedent's Name (First, Middle,	M #5 PER	INF C83	6_1071	3/04° JH	Dealii	2. Date of I	Reg. Ne		3. Time of Death
	Physici		Milton Dore		rry_				Month 9	Day	Year	9:22PM
-	/Medic Examir		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of I		4c.	County of Deat	1
		٠	Baltimore Rehal		EARnde			more			N/A	
	Funeral Director		5-220-03-4071	3. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. Ia 86	ast birthday) Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of 8. Month 1	Birth Day, Year) -191	_   Co	oplace (State or Foreign untry) Caster, Va.
			Usual Residence of Decedent						0 -1	101	О Пап	caster, va.
	rylan thow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	Director	Md. N/A		В	altim						1 XYes 2 □ No
	with th	Dire	10e. Street and Number	_			10f. Zip Code	_			izen of What Co	untry?
	eath	eral	3816 W. Roge	rs Ave.	dent Ever in U.S	S. 13. V	2121		n? (Specify Yes or I	US	A 14. Race - Ame	ncan Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked othar than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	y Funeral	1 Never Married Marrie	Armed Ford  1 XYes	ces? 2 🗌 No		fYes, specify Cuba □ Yes 2👿 No	an, Mexican, I Specify:	n? (Specify Yes or t Puerto Rican, etc.)		Black, White	e, etc.
21215-0036	hours tural	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's		tes: 42-4		lent's Usual Occup	ation		16h Ki	ind of Business/l	
15	in 72 n na	Completed	(Specify only highest	grade completed)	4==5.)	(Give	kind of work done	during most o	f working	100. K	ilid ot adsitiess/i	ridustry
212	d with giene.	mo:	Elementary/Secondary (0-12) 12	College (1-	40r 5+)	Con	structi	on Wo	rker	Con	struct	ion Co.
	2 should be filed withir and Mental Hygiene. Is marked other than aumatic evant, I. M.	Bec	17. Father's Name (First, Middle, La	ist)				18. Mother's	s Name (First, Midd	le, Maiden	Sumame)	
yla	should be fand Mental I	2		Curry					ica A. C			
Maryland	12 sh h and 7 Is m rraum		19a. Informant's Name/Relationshi						or Rural Route Num			
	1 and 1 Health em 27		Maxine Curry 20a. Method of Disposition	wile	20b. Pla	and the second second	sition (Name of natory or other place		Date	_	e, Mary	land 21215 Town, State
nor	ages ant of t: If it y or o		1 X Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe		tatte			1	-22-04			
Baltimore,	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Li		Ga.			1				
B	permit. Departr Imports any inju		Lloyd M E	step		1	step Br 300 Eut	aw Pl	s Funer ace,Bal	aı s timo	er,P.A re.Md.	21217
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that can	used the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ren		211 C	arcino	W1B				Onset and Death  Lear
	/Medical Examiner		resulting in death)	Due to (c	or as a consequ		KI CI IIV	11111111				1
	Lammer		Sequentially list conditions,	b. Due to /c	or as a consequ	ence of):						
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2001010	7 45 4 001130qu	01100 017.						
΄,	execul n and ial-tra	Exai	that initiated events resulting in death) Last	C. Due to (c	or as a consequ	ence of):						
8760,	ate be executed physician and the burial-transit	dlcal		d								
9	intifica ing ph a as th	0	IF FEMALE:									***
Вох	leath certific attending p I for use as	lan/l	23b. Was decedent pregnant in the past 12 months?		th 2 Fetal	death 3 [	Ectopic pregnancy	,			23d. Date of deli-	very Day Year
0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□ Unkno	int at time of de wn	ath 5∟	Other (specify)					,
٩	res that the de signed by the a l be detached f		Part II. Other significant condition	s contributing to de	ath but not resul	Iting in the ur	nderlying cause giv	en in Part I.	23e. Dio	tobacco u	ise contribute to	the cause of death?
Records,	quires n sigr ald be	ed by	prostote	Carcin	oma				1	Yes 2	No 3□Pro	bably 4 Unknown
000	aw requir s been si s should	Completed							24a. Wt		24b. Were au	opsy findings available ompletion of cause of
Re	sician: The law certificate has b irector, page 2 s	mo							per	opsy formed? 2 No	death?	2 No
Vital		BeC	25. Was case referred to medical examiner?					26. Place of	f Death (Check only			
of V	Physician: this certific ral director,	은	1 Yes 2 No		·	ER/Outpatien		4 🗌 Nursi	ing Home 5 Re			ify)
Ä	ling P	lon	27. Manner of Death 1   Natural 5   Pending	28a. Date o (Month	n, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe	how injur	y occurred	
Division	kttendi death. ctor: A y the fu	ficat	2 Accident investigat 3 Suicide 6 Could no	t be 28e. Place	of Injury - At hor	me, farm, stre	eet, factory, office	163 2 110		(Street an	d Number or Ru	ral Route Number,
οį	alor / s after if Dira	Certification:	4 Homicide	buildin	g, etc. (Specify)	)			City or T	own, State	)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the kaminer: On the ba and mann	sis of examinati	vledge, death ion and/or inv	occurred at the ting restigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time	e cause(s) e, date and	and manner as I place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		1		29c. Licens			29d. Dat	e signed (Month	. Day, Year)
	1		) Juli	E . Cal	U, M	1.0.	34	3590	0 H10)	9	150	4
	6		30. Name and address of person w. Toku S. Lak. m.D.	3 900 Loc	of death (Item	23a) (Туре, и Вош	levard	Balti	more, M	arula	and 21	218
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signati	ure	1			1		
	Regist	rar	SEP 2 2 200	4 July		0 4	water					

				Please			t in Black In ryland / Dep			_		Legible.	
		1	- State Registrar				•	rtificate of			Reg. No.	004	29910
		-	. Decedent's Nam	e (First, Middle, Las						2. Date of De	aath Day	Year	3. Time of Death
Phys /Me	ıcıaı dica	-	JUANITA	LOUISE C	OTTRELI					SEP	18	2004	6:40A M
Exan	nine			If not institution, give 'MD. SPEC			SPITAL		r Location of Death IORE CITY		4c.	County of Dea	ath
Funer Direct		5	. Social Security N 233-64-8	1	ex □ M 2 <b>X</b> F		(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di 9-17-	rth a <i>y, Year)</i> 1941	C	rthplace (State or Foreign country)
and w		-	Jsual Residence o I0a. State	f Decedent 10b. County			10c. City, Town or L	ocation					10d. Inside City Limits
Manyla f sho			MD.	BALTIMO	RE		RASPB	URG					1 ☐ Yes 2X No
r 28e		lec .	I0e. Street and Nu					10f. Zip Code				zen of What C	Country?
th with 23a c	- 1	ם -	5617 WHIT	BY RD.				2120				S.A.	1.00
after des		2	<ol> <li>Marital Status</li> <li>Never Marital</li> </ol>	ried 2 Married	12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	rces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes ¾☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify: WH	ite, etc.
ours a	:	20 0	3 🗌 Widowed	4 Divorced	Year or D	ates:							
"netu		ere	(Spe	<ol> <li>Decedent's Ecify only highest gra</li> </ol>	ucation de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	16b. Ki	nd of Busines	s/Industry
withir iene. then		Completed	Elementary/Seco	ondary (0-12)	College (1	1-4or 5		OUNTANT	-,		1	ÆCHANI	CAL
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  I marked of their then "neturel; or Items 23a or 28e-1 show eurnantic event, Italy Maryland Examinar must be notified.		o Re C	17. Father's Name	(First, Middle, Last)  PAUL WI					18. Mother's Nam HELEN E				
1 C, IVICIL 9 1C s 1 and 2 should f Health and Men item 27 Is marke other treumatic		-	19a. Informant's N	lame/Relationship (	Type, Print)				and Number or Ru VAY RASPB				Zip Code)
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other trei		İ	20a. Method of Dis	sposition  [XCremation 3 [	Removal from	State	1	matory or other pla	<sup>ce)</sup> 9-2	Date 2-2004		cation - City o	r Town, State E, MARYLAND
permit. Pa Department Importent any injury	once.	*4 □Donation 5 □Other (Specify) METRO CREMATURY											RAL HOME
4056	a	+	222 Parts Fotor	the disease or com	olications that	aused	the death. Do not en					0 21237	Approximate
Physicia	an -		shock, or he fmmediate Cause disease or conditi	art failure. List only (Final on	one cause on e	each lin	10.	ythemies		,			Interval Between Onset and Death
/Medic Examin			resulting in death)	ſ	Du to	or as:	a consequence of):		- disee	ire			1042
uted 3 ansit		Examiner	Sequentially list of cause. Enter Und Cause (Disease of that initiated event	mmediate lerlying r injury	Due to	(or as	a consequence of):						
be exect sician and burial-tra			resulting in death)	Last	Due to	(or as	a consequence of):						
ing physical of a street		Medic	IF FEMALE:								- 1	-	
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		Physiclan/Medical	23b. Was decede in the past 1: 1 Yes 2 9 Unknow	2 nonths?		birth nant at	2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	у			23d. Date of d Month	elivery Day Year
s that the		by Phy					ut not resulting in the	underlying cause gr	ven in Part I.				to the cause of death?
w requires been sign		ted	Chron	ic pena	1 yarı					1	Yes 2		Probably 4 Donknown
o E 9	1	Completed	End 1	stage r	enal.	والح	leare			24a. Wa aut per 1 \( \text{Yes}	opsy formed?	death?	autopsy findings available completion of cause of second 2 No
ysicien: The is certificate director page		Bec	25. Was case refe examiner?	erred to medical					26. Place of Dea	th (Check only	one)		
OT V Physic rthis ce		ဥ	1 Yes 2			Inpatie		ant 3 DOA		lome 5 Re			pecify)
on or of oding Phys h. After this of the oding of the oding phys	3	tion	1 V atural	5 Pending investigatio	28a. Date (Mor	nth, Da	y Year) Injury	Wo	rk? ]Yes 2□No	200. 50001100	711044 1111141	, 00001100	
or Attending Physicien: der death. Director: After this certific in by the financial director.	6	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not b	e 28e. Plac	e of Inj ling, et	ury - At home, farm, s c. (Specify)	treet, factory, office			(Street ar own, State		Rural Route Number,
To the Hospitel or Attent within 24 hours after death to the Funerel Director:			29a. Certifier (Check only		miner: On the b	oasis o	of my knowledge, de f examination and/or						
To the within 2	ald line	Medical	one) 29b. Signature ar	nd title of confiler	and mar	ner sta	aleU.	29c. Licen	se number		29d. Da	te signed (Mo.	nth, Day, Year)
F 3 F 8	1		1	Q.				D	30494		9.	- 18-	04
1	0		30. Name and ad	dress of person who	completed cau	se of c	leath (Item 23a) (Type	Print) hos	:pital	501 50	wth	chales	sh Balhmore MIDZ 1236
Y.,	01-	te	31. Date filed (Mo	onth, Day, Year)	32.	Regist	ars Signature	A. N.					
Red	Sta gistr	.3		SFP 2	2 2004	.3	Come St.	and the same					

DHMH 17 Rev 1/2001

nysicia Medic	n	1. Decedent's Name (First, Middle, Las	st)						Date of Dea     Month	ath Day	,	Year	3. Time 4:16	of Death
		Clarence		nry		Cam	eron		09	14	2	004	$\frac{1}{4} \cdot \frac{1}{3}$	ła.™
xamin	er	4a. Facility Name (If not institution, give				Town, or	Location of	Death		4c. (	County o	f Death		
neral		Future Care Nu: 5. Social Security Number 6. S		ge (In yrs. last birthday	If Under	1 Year	If Under 24	Hrs.	8. Date of Birt	h		9 Righnl	aco (Stato	or Foreign
ector		214-62-7063 Usual Residence of Decedent	X M 2□F	50 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 08 0	5 5	4	Count	ace (State ry) MD	or r oreign
Ē	,	10a. State 10b. County		10c. City, Town or L								10	d. Inside (	City Limits
diffe	ctor	MD NA		Baltimon	ce								1 XYes	2 🗌 No
De La	Dire	10e. Street and Number			10f. Zip		007			10g. Citiz			ry?	
THEST	era	3401 Windsor B	LVC  12. Was Decedent	Ever in U.S. 12	Was Deep		207	2 (0	W. W		J.S.			
or other traumatic event, the Mudical Everta artified at	by Funeral Director		Armed Forces: 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	If Yes, spec		n, Mexican, f	Puerto R	ify Yes or No- ican, etc.)			White, e	in Indian, itc. lack	
ical E	Completed	15. Decedent's Ed	lucation	16a. Dece	dent's Usua	al Occupa	ation	,		16b. Kin	d of Busi			
Med	npie	(Specify only highest gra	College (1-4or	5+) (Give	DO NOT us	rk done d se retired,	luring most o )	f working		Yell				
2		2th grade	na	D <sub>1</sub>	river								tion	Co.
raumatic event, the Med	m	17. Father's Name (First, Middle, Last)							First, Middle,		Sumame)			
matic	ဥ	Henry W. Camer  19a. Informant's Name/Relationship (1)		10b Maili	na Addross				Pool					
rtrau		Elizabeth Webb							Route Numbe B <b>alti</b>				<sup>Соде)</sup> 2120	7
any injury or other trau		20a. Method of Disposition		20b. Place of Dispo	osition (Nam	ne of		Da	-	20c. Loc				
ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State  ()	Metro C	•	•	1	0/	20/04	Bal	tim	ore	ь ма	
any nju once	ı	21. Signature of Furural Service Licen	see I	2:	2. Name and	d Addres	s of Facility	100	20/04	1501		.010	,	
E 8		Signette	75. X	Mes 4	300 W	√aba	West	7e,	Balti	more	. M	ld	2121	5
		23a. Part1. Enter the disease, or companion shock, or heart failure. List only	olications that caused one cause on each li	the death. Do not en	ter the mode	e of dying	, such as ca	rdiac or	respiratory ari	est,			Approxima Interval Be	te tween
ian		disease or condition	a	Jack	Mellil	Contraction of the Contraction o	мрттс	acio	lis.				Onset and	Death
al er	1	resulting in death)	Due to (or as	a consequence of):									1	<u>x —</u>
	-	Sequentially list conditions,	b	a consequence of):	3100				-1	100	NO		year	1
П	uin min	cause. Enter Underlying Cause (Disease or injury	000000000	A STREET, STRE	$n_{-a}$	V-SC	2010	78	LAUS	100	-D		Ura.	
	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence of):	100	7	Da a h	ot	WED BY MEDIC	AL EXAMIN	Ei.	-	1	7
	dicai		d					M APPRO	NED BY I				0	
3	Med	IF FEMALE:					TRI V							
	Physician/Me	23b. Was decedent pregnant in the past 12 months?	4☐Pregnant at	2 Fetal death 3	Ectopic pre	egnancy						of delivery		Year
detached	hys	9 🗆 Unknown	9□ Unknown											
pe c	þ	Part II. Other significant conditions co	ontributing to death b	out not resulting in the u	nderlying ca	luse give	n in Part I.		23e. Did to	bacco use es 2□		ute to the	_/	teath? Jnknown
Dino	a a								24a. Was a	n	24b. We	re autops	sy findings pletion of c	available
	<u>a</u> .								perfori		dea	th?	No	ause oi
page z snourd	Compi						26. Place of	Death (	Check only on	(e)				
page z should	œ	25. Was case referred to medical examiner?	112-1				0	na Home	5 🗆 Reside	ence 6 (	Other	(Specify)		
page 2 should	To Be	examiner? 1 XYes 2 3/10	Hospital: 1 ☐ Inpatie				+ Nursii							
200	To Be	examiner?  1 Yes 2 100  27. Manner of Death  N Netural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	unk 28	Bc. Injury Work	at ?	286	d. Describe ho	ow injury o	occurred			
Dage A special	To Be	examiner?  1 XYes 2 40  27. Manner of Death	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	unk 28	Bc. Injury Work 1 [XY	+ Nursii	Tr.	d. Describe ho	ow injury o	subj			
the funeral director, page 2 should	Certification: To Be	examiner?  1 X es 2 4 5  27. Manner of Death  1 Vetural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could not be determined	28a. Date of Inju (Month, Da)  1-2-2000  28e. Place of Inju building, et  Park	28b. Time of Injury  28b. Time of Injury  ury - At home, farm, str., (Specify)	M 28	Bc. Injury Work' 1 XY	at ? es 2 □ No	286 Tr	d. Describe hole  ee fel. f. Location (St. City or Town altimo	l on reet and l n. State)	subj Vumber o Pruic lary	or Rural I Hil Land	Route Num	har
page 2 should	Certification: To Be	examiner?  1 Yes 2 Ho  27. Manner of Death	28a. Date of Inju (Month, Date of Inju (Month, Date of Inju Injudicing, et Park  Visicien: To the best iner: On the basis of	y Year)  28b. Time of Injury  ury - At home, farm, str.c. (Specify)  of my knowledge, death of examination and/or in	M 28	Bc. Injury Work' 1 XY	at ? es 2 \( \text{No}\)	286 <b>Tr</b> 286 <b>B</b>	d. Describe ho ee fel: f. Location (Si City or Town altimo	l on reet and l r. State)	subj Number of	or Rural I Hi] Land	Route Num	rk
page 2 should	ledical Certification; To Be	examiner?  1 X Yes 2 4 5  27. Manner of Death  1 Accident  3 Suicide  4 Homicide  29a. Certifler (Check only one)  29b. Signature and title occurrier	28a. Date of Inju (Month, Da 1-2-2000) 28e. Place of Inju building, et Park  ysicien: To the best iner: On the basis of and manner sta	y Year)  28b. Time of Injury  ury - At home, farm, str.c. (Specify)  of my knowledge, death of examination and/or intated.	M 28 M eet, factory,	Bc. Injury Work' 1 XY	at ? es 2 \( \sum \text{No}\) No	286 <b>Tr</b> 286 <b>B</b>	d. Describe ho ee fel.  f. Location (St City or Town altimo) d due to the co at the time, do	l on reet and l r. State)	subj Number of Pruice lary	or Rural I Hill and er as stat	Poute Num L1 Pa	rk
led in by the funeral director, page 2 should	ledical Certification; To Be	examiner?  1 X Yes 2 4 5  27. Manner of Death  1 Accident  3 Suicide  4 Homicide  29a. Certifler (Check only one)  29b. Signature and title occurrier	28a. Date of Inju (Month, Da 1-2-2000) 28e. Place of Inju building, et Park  ysicien: To the best iner: On the basis of and manner sta	y Year)  28b. Time of Injury  ury - At home, farm, str.c. (Specify)  of my knowledge, death of examination and/or in	f unk 28 M eet, factory, n occurred a vestigation, 29c.	Bc. Injury Work' 1 XY office at the time in my opi	es 2 No	286 Processor 286 Blace, and	d. Describe ho ee fel: f. Location (St. City or Town altimo) d due to the ca at the time, d	l on reet and I n. State) Te, Nause(s) are and pl	subj Number of Pruice lary	or Rural I Hiland er as stat due to the	Poute Num L1 Pa	ber, rk

		1 - State	artment of Health and Mertificate of Death		ne No2004 29912
Dhysis		Decedent's Name (First, Middle, Last)		2. Date of Death	Oav Year
Physici /Medi	cal		Carmack  4b. City, Town, or Location of Death	Septembe	er' 15, 2004 2:00 PM 1
Examir	ner	4a. Facility Name (If not institution, give street and number) 6105 Pembrook Street	Frederick		Frederick
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month Day, 176 Une 9, 179	
Director		212-24-6756 1□M 2♥F 76 Yrs.	J	une 9, 19	928 Maryland
land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I.	.ocation		10d. Inside City Limits
Mary P-f eth	ţo	Maryland Frederick	Frederick		1 TYYes 2 □ No
with the 3s or 28s	I Direc	10e. Street and Number 6105 Pembrook Street	10f. Zip Code 21704	10g.	Citizen of What Country? U.S.A.
rs after death	by Funeral Director	11. Marital Status  1 Never Married 2 Married 2 Married  1 Never Married 2 Marrie	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
DESILITIOTE, INIGITY IGITION A LATE 13-00000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show important; if item 27 is marked other than "natural", or items 25s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified at 900s.	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired) PMAKET	ng	Dwn Home
d be filed v d be filed v ental Hygie ced other t c event, ID	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	den Sumame)
yian ould b Ments Ments arked	ToE	Francis Leo Steiner	Ruth	E. Smith	
and 2 shealth and a straum		Marion D. Carmack, Jr./Husband 610	)5 Pembrook Street,	Frederic	ck, Maryland 21704
DESILITION CONTROLL PAGES 1 2 Department of He mportant: If item in y injury or oth 2002.		20a. Method of Disposition  1 Surial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)	position (Name of enation of other place) sept.		E. Location - City or Town, State Frederick, Maryland
Dall permit. Departiment import		M00021	22. Name and Address of Facility  Keeney and Basfon	d Funeral	Home
		23a. Part1. Enter the disease, or complications that hused the death. Do not enshock, or heart failure. List only one cause on lach line.			0
Physician /Medical Examiner		disease or condition resulting in death)  a.     VIII   VI	Anenocaccinomi	PERLIC	ARDIUM
7 Mar	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. ADEVOCARCIVO  Due to (or as a consequence of):  c	MA OV LUPB		T Wentu
obfou, ificate be ex g physician as the burial	cai	d			
death cert death cert e attendin id for use	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
v requires that the peen signed by the hould be detached	by	Part II. Other significant conditions contributing to death but not resulting in the $HYPPnTCPSION$	underlying cause given in Part I.		co use contribute to the cause of death? 2 □ No 3 ☑ Probably 4 □ Unknown
e lav	Completed			24a. Was an autopsy performed	prior to completion of cause of death?
ysician: Thysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death		
this at di	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time		ne 5 A Residence	
_ b ē ē	tion	1 E Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation		Edd. Describe flow	injuly occurred
DIVISION ( a) or Attending F a after death. I Director: After d in by the funer.	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
To the Hospital or within 24 hours after To the Funeral Director completely filled in L	edicai Ce	29a. Certifier  (Check only one)  29 Medical Examiner: On the basis of examination and/or and_manner stated.			
o the orthe omple	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
- s - ō		that 170	D-31912		9/16/04
16		30. Name and address of person who completed cause of death (Item 23a) (Type TVL) NEWX NO. 1564 OPUSS	perint)	VEDE TIL	u mo 21702
	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	1	0 1-16	· · · · · · · · · · · · · · · · · · ·
Regis	trar	SEP 2 2 2004 Serve It	book		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician JAMES D. COLE, Jr. 12:40A September 13, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 201-14-7715 4/22/1926 Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or Itame 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at PA York 1 ☐ Yes 2X No Delta Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 384 Pikes Peak Road 17314 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White f Pes, Give Year or Dates: 1944–46 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Presbyterian Church USA 5+ Pastor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James D. Cole Helga Chellman ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 Is nay injury or other tree Amy J. Chetelet/Niece 485 Sumpter Drive, Perryville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greene Co., Memorial Park 9/18/2004 Waynesburg, PA ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 A1. Ento the disease, of complications that caused the death oo not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLORECTAL CANCER Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit Due to (or as a consequence of): ng physician a as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ OBSTRUCTION 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 to Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 DInpatient ٩ 2 ER/Outpatient 3 DOA 27. Manne Death 1 atural Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funerel L Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year 29b. Signature and title of certifier D3/275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUALDS mis

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

04-5298 B.K.S

Physic	ian	Decedent's Name (First, Middle, I	Last)							2. Date of Dea Month	ath Day	Yea	3. Time of
/Medi			l Cousins							AUG.	13,	2004	7:12
Examir	ner	4a. Facility Name (If not institution, of MERCY HOSPIT)	give street and num AL	ber)				Location of			4c. C	ounty of D	Peath
Funeral Director		none	. Sex 7 1 ☐ M 2 🔀 F	7. Age (In yrs. las	t birthday) Yrs.	If Under Months		If Under Hours	24 Hrs.	8. Date of Birtl (Month, Day Aug 13,	7 (Year) 2004		Birthplace (State of Country) aryland
M W		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Town or Lo	cation				···			10d. Inside Cit
f show	ō	MD			Ba.	Ltimo	re						11√∑Yes
28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What	Country?
3a or		2846 W. North Av	renue				21	216			,	USA	
ms 2	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.S.	13.	Vas Deced			gin? (Spe	ecify Yes or No- Rican, etc.)	14	. Race - A	merican Indian,
should be litted within 12 hours after beath with the marytain. Ind Mental Hygiene. Inarked other than "natural," or items 23a or 28a-f show Imarked other than "natural," or items 23a or 28a-f show Imatic avant, It a Modical Examinar must be notified at	by Fur	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 If Yes, Give	2 <b>X</b> No		r Yes, spec I⊡ Yes 2		n, мөхісаг Specify:	i, Puerto	Hican, etc.)		Black, W pec <i>ify:</i>	hite, etc. black
natural',	ted	15. Decedent's	Education	1	6a. Deced	lent's Usua	I Occupa	ition			16b. Kind	of Busine	ess/Industry
yene. Jene. rthan "natur	Completed	(Specify only highest (Specify only highest (Specify only highest (O-12)	College (1-	4or 5+)	life. I	kind of wor DO NOT us	rk done d se retired;	<i>luring</i> mos )	t of worki	ng			
giene grant than	оп	none	none		non	e					noi	ne	
al Hy d oth	Be (	17. Father's Name (First, Middle, La								(First, Middle,			
Ments Ments arked arked	10	Terrance	Roberts					Res	haye	Sierra	Cous	ins	
alth and I		19a. Informant's Name/Relationship O • C • M • E •	(Type, Print)		19b. Mailir 11	g Address l Pen:	(Street a	nd Numbe reet	or or Rura Balt	i Route Numbe	r, City or 1	own, State 21201	e, Zip Code)
permit. Fages I and 2 should be lined within a Department of Health and Mental Hygiens Important: If item 27 is marked other than "I any injury or other traumatic avant, I're Med once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☒ Other (Spe	С	Pate	20c. Loca	ition - City	or Town, State						
Departm Departm Importa any inju		21. nature Funeral Service Lic Ronal A	Wade D	irector	S	Name and tate altim	Anat	omy :	Board 2120	1 655 W.	Bal	timor	re Street
Medical passed and physician and the burial-transit	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate the first service. First lines from Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a consequen	nce of):								
ed by the attending ph detached for use as th	Physician/Med	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									230	d. Date of o	delivery Day Y
det det	by	Part II. Dther significant conditions	contributing to dea	ath but not resultin	ng in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	1		e to the cause of de Probably 4 🔲 U
n sign	Completed									24a. Was a autops perform	sy	24b. Were prior t death 1 <b>X</b> Y	
ate has been sign bage 2 should be		25. Was case referred to medical examiner?	Hospital:				Othe			Check onl on		-	
certificate has been signi rector, page 2 should be	Be		2 No Hospital: 1 Inpatient 24 SEP/Outpatient 3 DOA Cther. 4 Nursin Death 28a. Date of Injury 28b. Time of 28c. Injury at								ow injury o		pecify)
n, After this certificate has been signifuneral director, page 2 should be	To Be	1X Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of (Month)	Day Year)	Injury			00 01					
ifer death.  Niractor: After this certification by the funeral director.	To Be	1X Yes 2 □ No 27. Manner of Death	28a. Date of (Month,	of Injury - At home		М	1 🗆 Y	'es 2 □ l		28f. Location (St City or Town		lumber or	Rural Route Numb
ifer death.  Niractor: After this certification by the funeral director.	Certification: To Be	1X Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 2 Accident 3 Suicide 6 Could not determine  29a. Certifier 1 Certifying	28a. Date of (Month, she ad 28e. Place of building)  Physician: To the base aminer: On the base	of Injury - At home g, etc. (Specify) pest of my knowle	o, farm, stre	M eet, factory,	1 □ Y	e date an	d place, a	City or Town	n, State)	d manner	as stated
ifer death.  Niractor: After this certification by the funeral director.	To Be	1X Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  27. No 5 Pending investigat 6 Could not determine	28a. Date of (Month, on the beat of building)  Physician: To the beat of the b	of Injury - At home g, etc. (Specify) pest of my knowle	o, farm, stre	M eet, factory, occurred a restigation,	1 □ Y	e, date an inion, deat	d place, a	City or Town	n, <i>State)</i> ause(s) an ate and pl	d manner ace, and d	as stated
if creations represent the death.  Diractor: After this certification by the funeral director.	edical Certification: To Be	1X Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigat 2 Accident 3 Suicide 6 Could not determine  29a. Certifier (Check only one)  27. Manner of Death 5 Pending investigat determine	28a. Date of (Month, she ad 28e. Place of building)  Physician: To the base aminer: On the base	of Injury - At home g, etc. (Specify) pest of my knowle	o, farm, stre	M eet, factory, occurred a restigation,	1 TY office at the time in my op	e, date an inion, deat	d place, a	City or Town	n, <i>State)</i> ause(s) an ate and pl	d manner ace, and d igned (Mo	as stated. lue to the cause(s)

			1 - State of Management  State of Management  State	aryland / Depa	artment of He			ene g. No.	4 2	9915
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Ellis T. Cline				2. Date of Death Month	Day	Year OOU	3. Time of Death 5: 30 PM
	Examir		4a. Facility Name (If not institution, give street and number) SomERFORD ASSISTED	LIVING		RSTOW		4c. County	of Death	SETON
	Funeral Director		5. Social Security Number  219-05-2819  Usual Residence of Decedent  6. Sex  1 ☑ M 2 ☐ F  7. Ag	ge (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 31,	<sup>Year)</sup> 1919	9. Birthpi Count Mary]	lace (State or Foreign try) Land
	e Maryland 3a-f show tiffied at	ctor	10a. State 10b. County MD Washington	10c. City, Town or Lo	erstown				10	0d. Inside City Limits 1 ☐ Yes 2 No
	h with th	ai Dire	10e. Street and Number 10116 Sharpsburg Pike		10f. Zip Code	740	10	g. Citizen of \	What Count	try?
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show all yinjury or other traumatic event, the Medical Examinar rusal by itemidial at all DICE.	d by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 ☒ Yes 2 □ If Yes, Give Year or Dates:	41-45		Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - America ck, White, e	etc.
21215-0036	within 72 liene. than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or state of the content of the	(Give	dent's Usual Occupati kind of work done du DO NOT use retired) engineer	ring most of worki	ng	6b. Kind of Bu	usiness/Ind	•
	ild be filed lental Hygie ked other ilc svent, the	To Be C	17. Father's Name (First, Middle, Last)  David Frederick Cline			18. Mother's Name Beulah (	(First, Middle, M	laiden Suman		/stem
Maryland	and 2 should ealth and Men n 27 Is marke ier traumatic	-	19a. Informant's Name/Relationship (Type, Print) Somerford Asst Living		ng Address <i>(Street an</i>					
Baltimore,	Pages 1 a ment of Hea ant: If item ury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)	20b. Place of Dispo		D		Oc. Location ~		
Balt	permit. Departn Imports any inju		1-men/////	ctor St Ba	2. Name and Address ate Anatom 1timore, M	ny Board 1D 21201	655 W. I	Baltimo	re St	reet
	Physician /Medical		resulting in death)	d the death. Do not entine.  CANCE	er the mode of dying,	such as cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):  a consequence of):						
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat	e of deliver	ry Day Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death b	out not resulting in the u	nderlying cause given	in Part I.				e cause of death?
Il Records,	stcian: The taw require certificate has been si irector, page 2 should b	Completed					24a. Was an autopsy perform	ed?	prior to com leath?	osy findings available apletion of cause of
n of Vital	Phy rald	n: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatie  27. Manner of Death  28a. Date of Injunction (Month, Date of Injunction)		nt 3 DOA Other:	4   Nursing Hor	(Check only one ne 5 Resider Red. Describe how	ice 6 Oth	er <i>(Specify)</i>	ASSISTED
Division of	or Atten ifter deat Sirector: in by the	Certification:	2 Accident investigation	jury - At home, farm, str ic. (Specify)	M 1 ☐ Ye	s 2 No	28f. Location (Stre City or Town,	eet and Numb State)	er or Rural	Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai Ce	29a. Certifier (Check only one)  1 **Ecrtifying Physician: To the best 2 **Medical Examiner: On the basis or and manner street.	it examination and/or in	h occurred at the time, vestigation, in my opin	, date and place, a nion, death occurre	and due to the cau ad at the time, dat	use(s) and ma	nner as sta and due to t	ited. the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier		29c. License r	number 2 1457	29	d. Date signed	(Month, D	ley, Year)
			30. Name and address of person who completed cause of d		Print) K HILL	AVE.	HAGE	2 STO	WN.	mo 21740
	Sta Regist		31. Date filed (Month, Day, Year) 32. Tegistr SEP 2 2 2004	rar's Signature	antes				1	

04-5807 B.K.S

	ANNE		ALILIM 1 - State Registrar	State of M	Marylar	-	artmen rtificate					jiene 10g. NG. () (		29916
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic	al.	Anne Callum  4a. Facility Name (If not institution,		and the same of th			-		15 .	AUG.		004	11:15 A M
	Examin	er	3509 WOODLAWN		or)		-		Location of			4c. Count	y of Death	
	Funeral		5. Social Security Number unk	.Sex 7 1□M 2\\ F		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	, Year)	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent		61	Yrs.	11				Month Day Dec 12,	1942		. dirk
	yland		10a. State 10b. County		10c. Cit	y, Town or L	ocation							10d. Inside City Limits
	a-f st	ctor	MD		Bal	ltimor	2							1X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip	Code	**			10g. Citizen of	What Cou	ntry?
	s 23a		3509 Woodlawn A						1215				USA	
	Item Item	Funerai	11. Marital Status U  1 ☐ Never Married 2 ☐ Married	n k12. Was Decedei Armed Force 1 ☐ Yes 2 [	s?		Was Deced If Yes, spec	lent of His ify Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - Ameri ick, White,	can Indian, etc.
920	within 72 hours after death with the Maryland ene. then 'neturel', or Items 23e or 28e-f show he Madical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		unk	1 ☐ Yes	2 <mark>∏</mark> No	Specify:			Specia	⁄у: b]	ack
2-0	72 ho	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usua kind of wor	I Occupa	tion	4 = £	unk	16b. Kind of E	lusiness/In	dustry unk
21	ithin se.	nple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT us	e retired)	uring mosi	t of work	ng			
2	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or Items 23e or 28e-f show event, Itse Middeal Examiner must be notified at		unk 17. Father's Name (First, Middle, La	unk		<u> </u>		1.	10 Matha	uda Massa	/Fina Middle	14-14		
and	ld be fental h	To Be	Tr. Fathor S Mario (First, Middle, Ed	31/			ι	ınk	16. MOLNE	ar s ivame	(First, Middle,	Maiden Sumai	ne)	unk
Maryland 21215-0036	2 should be and Mental Is marked eumatic ev	<b>!-</b>	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Rura	Al Route Numbe	r, City or Town	, State, Zij	Code)
	and 2 ealth a n 27 is		O.C.M.E.						et B	alti	more, M	2120	1	
Baltimore,	permit, Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke eny injury or other treumatic: once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5 Other (Spe		te	Place of Dispo cemetery, crea	osition (Nam matory or o	ne of ther place	a)	C	Date	20c. Location	- City or To	own, State
Balti	permit. Departrimporte eny inju		21. Signature of Funeral Sovice Lin	Wade, Din	ector	S <sup>2</sup> t Ba	2. Name an ate A	d Address	s of Facilit my Bo MD	y Dard 21201	655 W.	Baltim	ore S	treet
			23a. Part1. Enter the disease, or or shock, or heart failure. List or	omplications that caus	ed the deat							est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			e Arte	eriosc	lero	tic (	Card:	iovascu]	ar Dis	ease	Onset and Death
	/Medical- Examiner		resulting in death)	a	as a conseq									
	- X	<u></u>	Sequentially list conditions,	b										
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseq	uence ot):								
Ć,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or a	as a conseq	uence of):								
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicall		d										
9	rtifical ng phy as th	Jedi	IE CEMAL C.											
Вох	eath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			∃Ectopic pre	egnancy					te of delive	•
0	the a	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknown		eath 5	Other (spe	ecify)				Mic	onth	Day Year
<u>a</u> .	that the de led by the a detached t	/ Ph	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	pacco use con	tribute to the	ne cause of death?
Vital Records,	w requires that been signed to should be det	d by												ably 4 🛣 Unknown
Ö	law rec as bee 2 shou	olete									24a. Was a	n 24b	Were auto	psy findings available
Re	Ф <u>г</u> <u>Ф</u>	Completed									autops perform	ned?	prior to co. death?	mpletion of cause of
ita	ystcien: Th	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on		1 🗌 Yes	Z M NO
	ys dii	2	1. Yes 2 □ No	Hospital: 1 ☐ Inpa		ER/Outpatier			4 🗆 1901	rsing Hor	ne 5 🗆 Reside	ence expoth	er (Specif	AT SCENE
o U	ding Ph h. After th funeral	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Ir (Month, L	jury Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe ho			
isio	Attending ir death. ector: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could no	be 00- 51(1	niuna. At ha		M		es 2 🗆 N		206 )			
Division of	ol or Attence after death Director: d in by the	Certification:	4 Homicide determine	28e. Place of I building,	etc. (Specif	y)	eet, factory,	опісе		4	City or Town	reet and Numb n, State)	er or Hura	l Route Number,
	Hospitel 24 hours a Funerel D		29a. Certifier 1☐ Certifying	Physician: To the be	st of my kno	wledge, deat	n occurred a	at the time	e, date and	d place, a	and due to the ca	ause(s) and ma	anner as si	ated.
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	ledical	(Check only 2XXVedical Ex	aminer: On the basis and manner	of examina	tion and/or in	vestigation,	in my opi	nion, deat	th occurre	ed at the time, d	ate and place,	and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier	4.11	To A. A.			O.C.			2	9d. Date signe AUG • 3		
,			ramel )	ruirau /	111)									
_			30. Name and address of person where Permeter E. Soul	Will MD.	death (fter	1 23a) (Туре, 11 Per	n Str	æt,	Balt	timoı	re, Mary	land 2	1201	
:	Sta Registr		31. Date filed (Month, Pax, Year) SEP 22	2004 32. 69is	strar's Signa	ture	rede							

UNK 04-				State of Mem 23a,27,28					•	~	ible.	017
						Cel	Tificate of	Death			14 60.	711
AKG	Physicia /Medid		Decedent's Name (First, Middle	Parmeshv	ar C	handra			2. Date of D Month Septe	Day	Year	e of Death
	Examin		4a. Facility Name (If not institution	, give street and number)			4b. City, Town, o	or Location of De	eath	4c. County	y of Death	
			Woods behind 14633 s	Settlers Landir	ng Way	7	North P	otomac		Mon	tgamery	
1316	Funeral Director		5. Social Security Number 051-46-2760	6. Sex 7. Ag 1X M 2□ F		last birthday)	If Under 1 Year Months Days		in (Month D	rth ay, Year) • 1942	9. Birthplace (Sta Country) India	te or Foreign
	ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation			<del></del>	10d. Inside	e City Limits
	death with the Maryland rms 23a or 28a-f ehow r.r.ust.be.rottffred at	Director	Maryland Montg	omery		Nort	h Potoma	C		10g. Citizen of		/es 2⊠No
	with 3a or	ΙD	14633 Settlers	Landing Way	7			20878			ed States	
	heath hs 2	era	11. Marital Status	12. Was Decedent	Ever in U	J.S. 13. V	Nas Decedent of H		(Specify Yes or Nerto Rican, etc.)		ce - American Indian	
36	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Importent: If item 27 is marked othar than "naturel", or Itams 23a or 28a-f ehow any injury or othar treumatic event, Ite Medical Examited out by notified at once.	by Funerai	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 反 Divorced	Armed Forces?  ed 1 ☐ Yes 2 ☒  If Yes, Give  Year or Dates:			fYes, specify Cub 1□Yes 2☑No	an, Mexican, Pu Specify:	èrto Rican, etc.)	Bla Specii	ck, White, etc. <sup>'y:</sup> Asian-:	Indian
Maryland 21215-0036	72 hou	eted	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usual Occup kind of work done	pation	vorkina	16b. Kind of B	usiness/Industry	
121	within nne. Ihan "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retire	d)	· · · · · · · · · · · · · · · · · · ·	Colf F	nn 1 orra d	
io To	iled v Hygie thar t		17. Father's Name (First, Middle, I			Engin	eer	18 Mother's N	lame (First, Middle	1	nployed	
anc	d be f antal } ced of	To Be	Anjaiah Adigal	,					ıntala Ba		110)	
<u> </u>	shoul nd Ma mari	-	19a. Informant's Name/Relationsh			19b. Mailir	g Address (Street	and Number or	Rural Route Numb	per, City or Town	State, Zip Code)	
	nd 2 :		Karam Chandra/B	rother							yland 208	41
ą.	s 1 a if Hea item otha		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of natory or other place		Date		- City or Town, State	
Ĕ	Page nent o		1 ☐ Burial 2 🖾 Cremation  1 ☐ Donation 5 ☐ Other (Sp				Crematoriu	DCI	ot. 18, 2004	Bethesd	a, Maryla	ınd
Baltimore,	parmit. Departn Importe any inju		21. Signature of Funeral Service I	Licensee	м001	oo Ro	Name and Addre	Pumphre	y Funera	1 Home/R	ockville,	Inc.
			23a. Part1. Enter the disease, or	complications that cause	d the deat		or the mode of dyir	ntgomery ng, such as card	AVE., KO liac or respiratory a	CKV111e , arrest,	MD 20850— Approxii	mate
	Pnysician		shock, or heart failure. List Immediate Cause (Final disease or condition	Thermal		uries					Interval Onset a	nd Death
	/Medical-		resulting in death)	aDue to (or as								
	Examiner	<u>_</u>	Sequentially list conditions,	b. — Due to (or as	2.000.000	uonco of):						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	(uerice or):						
ć	te be axecuted ysician and e burial-transit	Exa	that initiated events resulting in death) Last	CDue to (or as	a consec	quence of):						
760,	te be iysicia ne bur	cal		d								
89	entifica ing ph e as th	Med	IF FEMALE:									
). Box 68	The law requires that the death certificate to has been signed by the attending physbage 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	aldeath 3□	Ectopic pregnancy Other (specify)	<i>'</i>			te of delivery onth Day	Year
P.O.	hat the		9 □Unknown  Part II. Other significant conditio		ut not res	sulting in the u	rderlying cause on	en in Part I	23e Did	tobacco use con	tribute to the cause	of death?
ords,	en signe	ted by								Yes 2 No	3 ☐ Probably 4	
Division of Vital Records,	rsicien: The law ra s certificate has be lirector, page 2 sh	Completed								psy ormed?	Were autopsy findin prior to completion of death?	gs available of cause of
tal		Be C	25. Was case referred to medical					26 Place of F	1 X Yes Death (Check only		1 Yes 2 No	
<u>&gt;</u>	tysici iis cer direc	To B	examiner? 1. <b>∑</b> Yes 2 ☐ No	Hospital: 1 ☐ Inpatio	ent 2	ER/Outpatien	t 3 DOA Cth				er (Specify) at	scene
0	ng Pł		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju	y Year)	Found	28c. Injur Wor	y at k?	28d. Describe	how injury occur	red	
sio	tendi leath. lor: A the fu	cati	2 ☐ Accident investig	9-11-04		2:50	P .	Yes 2 XNo	Name of the last o	molatio		
<u>iv</u>	or At after d Direct in by	Certification;	3 Suicide 6 Could n 4 Homicide determi		ury - At h c. <i>(Specii</i>	ome, farm, str fy)	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State) 146	33 Settle	rs Land
	pitel ours a eral (		29a. Certifier 1 ☐ Certifyin	g Physician: To the best	of my kny	anladaa daatt	occurred at the time	no data and als			Potomac,	Md
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: Atter this certifica completely filled in by the funeral director, I	edicai	(Check only 2 Medical I	Examiner: On the basis of and mariner st	f examina	ation and/or inv	estigation, in my o	pinion, death or	ccurred at the time,	date and place,	and due to the caus	e(s)
	To the within To the comp	Me	29b. Signature and title of certifier				29c. Licens			_	d (Month, Day, Year	
			Yanat Da	thay, MD			O.C.1	4.E.		Septembe	er 12, 200	04
			30. Name and address of person of Pamela F. Sc	who completed cause of c	leath (Iter	п 23а) (Туре,		Street	. Baltim	one. Mai	cyland 21	201
:	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature		aks/	,		- <del>/</del>	
•		40		/			- 1400	-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #20b&c PER FH C835 ertificate of Death Reg. No. 29919 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year Month **Physician** 11:30 PM COX 17,2004 GLORIA September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner topkins 7. Age (In yrs. last birthday, he Johns tom sire If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 □ M 2 Ø F 3 North 214-62-992 Yrs. Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location arthen "naturel", or Items 23a or 28a-f show The Medical Examiner must be colified at 1 Yes 2 □ No Maryland Directo more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1618 2121 Tue Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status 1 Yes 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates: Blac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I srownie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Informant's Name/Relationship (Type, Print) (Mother) perrait. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tret once. Brownie Moore Ve 20b. Place of Disposition (Name of CARDENS DUNDALK, MD. Town, State Date 20a. Method of Disposition 9/24/2004 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 22. Name and Address I Facility
JUSTAL Home
12222 W. North Ave. Balto. Nid. 21216 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Part I Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumatosis intestinal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner h-c Alcoholis Dout Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a consequence of) Examine The law requires that the death certificate be executed Acute attending physician and for use as the burial-tran rena Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be del Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 2 **X** No this certificate 1 Yes 1 ☐ Yes or Attending Physicien: the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examine Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 X No 28c. Injury at Work? 28a. Pate of Injury Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 September 17,2004 MD 11 Dem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Baltimore, MD Gewin Wolfe

Registrar

State

31. Date filed (Month, Day, Year)

SEP 2 2 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death September 21,2004 **Physician** Laura Leona Dean 6:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mariner Health at North Arundel Glen Burnie Anne Arundel 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign July 11,1916 Maryland **Funeral** Days Hours 1 □ M 21 F 88 220-20-8132 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Caroline Preston Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24270 Mallow Dr. 21655 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Midowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 2 should be tited within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Simon W. Kindle Lucy E.A. Toms ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a Important: If item 27 Is any injury or other tra Betty A. Smith / Daughter 24270 Mallow Dr., Preston, Maryland 21655 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 23, 2004 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metro Crematory, Inc. Catonsville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur / Funeral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Probable **Physician** cardiac Couple minutes /Medical Due to (or as a consequence of): SEVENAL Examiner CARDIOVASCYLAR DUEASE THERO EROTIC YEMRS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the burial-transit certificate be executed SYEHA MELLITY DIABETES and that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \( \text{Yes} \) 2 \( \text{Latvo} \) 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ RIGHT BRENST 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death Check on one examiner? Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the l 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBER 21,2004
PASADENA and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

SEP 2 2 2004

31. Date filed (Month, Day, Year)

BALTIMORE ANNAPOLLS BIVD MD 21122

1- State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Mary Dobernick 20 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Year If Under 24 Hrs. 8. Date of Birth 5-28-249. Birthplace (State or Foreign Min. Month. Days Year) 224

April 28, 1924 Square Roseda If Under 1 Year If Und Hospital 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2**X**□ F 80 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location \*how ms 23a or 28a-f shortman MD Baltimore Essex Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Avenue Apt 215 21221 USA Funeral r than "natural", or Items : the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No ff Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: \$ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) obernick, 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank 12 years Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be fi h and Mental H 7 is marked oth Be Theodore Deck Mary Spano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a William Schaeffer nephew 1000 Franklin Avenue, Essex, Md. 21221 Baltimore, Hem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 20c. Location - City or Town, State ō 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) = 5 Important: If eny injury o once. Bayview Crematory 21,2004 Baltimore City, MD. permit. 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licenses mil 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Infection **Physician** Overwhelming /Medical Due to (or as a consequence of): **Examiner** be quantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumonio Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed sthma Due to (or as a consequence of): Box 68760. Physician/Medical use as i IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. been sig 1X Yes Completed 24a. Was an has certificate ha

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

21222 Approximate Interval Between Onset and Death 3 days day 23d. Date of delivery Year Dav 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 20/04 Franklin Square Orive Bultimore MJ 21237

3. Time of Death

10d. Inside City Limits

1 Yes 2 No

Year

Black, White, etc.

-2004

State

or Attending Physician:

After

death.

after death Director:

within 24 hours a To the Funeral I Hospital

the

in by

Be

Certification; To

Medical

31. Date filed (Month SE

25. Was case referred to medical

5 Pending

investigation

6 Could not be determined

1 Yes 25 No

examiner'

27. Manner of Death

2 Accident

3 Suicide

4 - Homicide

(Check only one)

29b. Signature and title of

30. Name and address of person

↑ Natural

on who completed cause of death (Item 23a) (Type, Print) Registrar's Sign rare

28a. Date of Injury (Month, Day Year)

Registrar

28b. Time of

28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

D061104

1 ☐ Yes 2 ☐ No

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 05:27 AM eptember JUNIUS Dodo 200 /Medical Eacility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Hosptial Ja, Lohnes If Under 1 Year Birthplace (State or Foreign Country) 7. Age ( yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Min. Months Hours 1 XM 2 ☐ F Maryland 06/21/1942 Director 217-40-4065 62 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other treumatic avant, the Medical Esticitud must be notified at once. 10a. State 10b. County 1 ☑ Yes 2 ☐ No Directo Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 U.S.A. 1833 North Collington Avenue by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Improvement Contractor Home Improvement 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rachel Elizabeth Smith Leonard Dodd ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1833 North Collington Ave., Baltimore, Maryland 21213 Deborah Dodd / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/24/2004 Druid Ridge Ceme. Baltimore, Maryland \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Sign yur of Funeral Ser 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part If Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician 3 day Widespread arterial occivition disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NKNOW Trausseaus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetat death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 2 🗆 No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 X Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 은 1 🗌 Yes this the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Res -000 9-20-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ũ. Wolf Baltimore (or1 Wierks 600 21237 Registrar's Signa 31. Date filed (Month, Day, Year) State SEP 2 2 2004

DHMH 17 Rev 1/2001

Registrar

/Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show eny injury or other treumatic event, I'm Mudical Exercites in an invariate multified at

Baltimore, Maryland 21215-0036

ARLTON

DICKENS

	Pleas	se Type or Print in	Black	Indelible Ink	. Ensure All	Copies A	e Legible.			
	For	State of Maryla	nd / De	epartment of H	lealth and M	ental Hygie	ne			
	1 - State Registrar		C	Certificate of	Death	Reg.	No. 1) 114	29922		
	1. Decedent's Name (First, Middle	a, Last)				Date of Death     Month	Day 17 t Year	3, Time of Death		
ian cal	CARLTON	DICKENS				Septemb	er 12 th 20	4 3:25 PM		
ner	4a. Fecility Name (If not institution	-		4b. City, Town, o	or Location of Death		4c. County of Deat	th		
	STAGNES	HEALTHCAR	3.		IMORE					
	5. Social Security Number	6. Sex 7. Age (In yrs		Months Davs	Hours Min.	8. Date of Birth (Month, Day, Ye	$_{ m par)}$ $^{196}$ $^{19}$ . Birt	hplace (State or Foreign buntry)		
	214-84-9267	42	Yrs	5.		ctober 2		SHINGTON, DC		
	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town o	or Location				10d. Inside City Limits		
5	MD Howa	ard	Co	atonsville				1 ves 2 □ No		
ect	10e. Street and Number	ira	Ca	10f, Zip Code		10g	Citizen of What Co	ountry?		
0	8 Rambling Oaks	Way # T		21042				,		
era	11. Marital Status	12. Was Decedent Ever in U	IS.	13. Was Decedent of F		city Yes or No-	U.S.A.	rican Indian.		
5	1 Never Married 2 Marri	Armed Forces?		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black,				e, etc.		
Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	Black		
ted	15. Decedent	t's Education	16a. D	ecedent's Usual Occup	. Kind of Business/					
pje	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)	- 'ii	Give kind of work done ife. DO NDT use retire	d)	g				
5	12th		Eng	gineer			Private			
Be (	17. Father's Name (First, Middle,				18. Mother's Name		den Sumame)			
2	Donald E. Di	ckens			Pongee	White				
	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Pongee J. White/Mother									
	15/4/ Pointer Ridge Drive Bowie, Marylan									
	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation		Place of D cemetery,	Disposition (Name of crematory or other place	. Location - City or	Town, State				
	`4 □ Donation 5 □ Other (S)		rmony	y Cemetery	aryland					
1	21. Signature of Funeral Service	Licensee		22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785						
	1 K-D. Ma	rshall		7474 Land	over Road	Landover	, Mary⊥an	d 20/85		
	23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death)  a Metastatic Squamous Cell tongue Concer (resulting in death)									
	resulting in death)  Due to (or as a consequence of):									
	Sequentially list conditions									
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of)	):						
am	that initiated events resulting in death) Last	С								
Ē	resulting in death) cast	Due to (or as a conse	quence or)	):			i			
lica		d								
Mec	IF FEMALE:	22a Musa - 1								
ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death	3 Ectopic pregnancy	у		23d. Date of deli	ivery Day Year		
Physician/Medical Examiner	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death	5 Other (specify)				,		
Phy		 ons contributing to death but not re	sulting in th	he underlying cause div	ven in Part I	23e. Did tobac	co use contribute to	the cause of death?		
þ								/		

**Physician** /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Completed

Be

Certification: To

Medicai

Division of Vital Records, P.O. Box 68760,

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown

24a. Was an autopsy performed? 2 No 1 Tes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred examiner?	d to medical
27. Manner of Death	c (704)-

5 Pending 1 Natural
2 Accident investigation 3 Suicide

Hospital: 2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

29a. Certifier

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6695 BABATUNDE September 12th 2004 OLYMIDE, MD

STAGNES H
31. Date filed (Month Pay-Year) 2004 HEAUTHCARE
Registrar's Signature

State Registrar

			For State Registrar	State of Marylan	•	irtment of H tificate of I			ene g. No. 0 0 4	29923
	Physicia		1. Decedent's Name (First, Middle, Last) $He 1e n \label{eq:helicity}$		Davis  2. Date of Month Septe			Day Yea	3. Time of Death 04 2:20 P.M	
r.	/Medic Examin		4a. Fecility Name (If not institution, give s		0 .	•	Location of Death		4c. County of De	eath
	Funeral Director		Northampton Ma 5. Social Security Number 6. Sex 215-18-2597			If Under 1 Year Months Days	ederick  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, NOV 12,	9. F	Frederick Birthplace (State or Foreign Mary Land
	D		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	ith the Mar or 28e-f s	Director	Maryland Freder  10e. Street and Number 5117 Doubs Road	ick		10f Zin Code	stown 21710	10	g. Citizen of What U.S.A	1 □ Yes 2 No Country?
020	n 72 hours after deeth with the Maryland "naturet", or trems 23a or 28e-f show cotcal Examiner must be motified at	by Funerai		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 X No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Al Black, W Specify: Wi	
	filed within 72 hor Hygiene. Ither then "netura int, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Deced (Give life. L Secre	OO NOT use retired	ation during most of work ()		6b. Kind of Busine	
land 2	be de la la la la la la la la la la la la la	To Be Co	17. Father's Name (First, Middle, Last)  Carl Jay Davis		1		18. Mother's Name Mary	e (First, Middle, M Stup	laiden Sumame)	
Mary	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic	7	19a. Informant's Name/Relationship (Type Evelyn Ott/Sister	oe, Print)		-	and Number or Run ad, Adams		-	
more,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20058.		20a. Method of Disposition  1 M Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)	emoval from State Mt.	Place of Dispo	sition (Name of pat Cember 84	y Sept. 1	7, 2004 <sup>2</sup>	Oc. Location - City Frederic	or Town, State Ck, Maryland
Baltimor	permit. Departmit. Importa any inju		21. Signature of Funeral Service License	Basta NO	0021 K		d Basford			
	Physician /Medical Examiner	-6	23a. Pent 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	yocan	dial Ir		of Pespilatory Enfe	ęderick,	MD Approximate Interval Between Onset and Death Municipal States of the Control o
58760,	reate be executed physicien and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	•	onic obstructive pulmonary disease year as a consequence of):					
O. Box (	death certif e attending id for use a:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 memths? 1 □ Yes 2 ② No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
2	The law requires that the tee by the bas been signed by the bage 2 should be detache	by	al altition in a file of the allite a							to the cause of death?  Probably 4 □Unknown
l Reco		Completed			24a. Was an autopsy performed 1 □ Yes 2 №			autopsy findings available to completion of cause of ? es 2 \( \text{No} \)		
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth		h (Check only one		
Division of Vital Records,	ling Phys I. After this funeral dis	ition: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	4 Nursing Ho	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred		
Divis	tel or Attences after death	Certification:	2 Accident		/ - At home, farm, street, factory, office 2			28f. Location (Str. City or Town	Rural Route Number,	
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mo	
1			Kaffileen W	sen No	0	D;	32073		9/17/0	4
	15		30. Name and address of person who co	Skem MD	m 23a) (Type,	10 Nir	the are	Bour	rswich 1	4 4d 217/6
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regisfrar's Sign:	ature	Sperker				

		-	For State Registrar	State of Marylan		rtment of F			ene	1, 2	9924
		1 Decedent's Name (First Middle, Last) 2. Da							2. Date of Death  3. Time of Death		
	Physicia	-	I	da Helen Dani	els				eptember 19 2004 4:00 A.M		
	/Medic Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death	1	4c. County o	f Death	
			Millennium Nursi				Burnie	1		Arun	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 2,	<sup>Yea</sup> r) 1919	Country Mary	ce (State or Foreign 1) 1 and
7.	Director		218 03 4694	0.5				oury 2,	1919	MALY.	Land
	/land		10a. State 10b. County	10c. Cit	y, Town or La	cation				100	I. Inside City Limits
	Man,	tor	Maryland Anne Ar	undel B	altimo	re					1 ☐ Yes 21X No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country	<b>y</b> ?
	23a		5811 Redmond Str			212			U.S.		to dian
21215-0036	in 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show polical Executive cours be notitied at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	<ul> <li>12. Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No tt Yes, Give Year or Dates:</li> </ul>		Was Decedent of F f Yes, specify Cubi 1 ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black	- Americar , White, et Whit	c.
9	2 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation during most of wor		6b. Kind of Bus	siness/Indu	stry
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	7 7 7	Completed	8th		Cle	erk	10 Mathada Nos	ne (First, Middle, N			Cledit
Maryland	o d is D	To Be	17. Father's Name (First, Middle, Last) Walter E	merson Daniel			Mai	ry Ellen	Smith		
lan	2 sh and and ls m	•	19a. Informant's Name/Relationship (Ty)					ral Route Number, Baltimo			
	1 and Health Iem 27 other tr		Mary Tormollan	/ Daughter	1	Redmond	Street		20c. Location - 0		
ore	00==		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → R	emoval from State	emetery, crei	natory or other pla				•	
Baltimore,	permit. Pages Department of Importent: If it any injury or o		. 4 □ Donation 5 □ Other (Specify)  21. Signature of Funerat Service License	_	2:	11 Cemete	ess of Facility G	once Fune	eral Ser	vice	
	89779		Jerome gra	museum			nie Highw				land 21225
Į	Physician		23a. Fant. Enter the disease or complishock, or heart failure. List only or tmmediate Cause (Final disease or condition	ne cause on each line.	0.002		acci	Α.	151,	1	nterval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	juence of):						
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a consec	ruence of):						
	ate be executed nysician and he burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	uence of):						
8760,	ate be ex nysician he burial	置			, , , , , , , , , , , , , , , , , , , ,						
387	phys phys s the	edical		l							
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date Mon	of delivery	/ ∂ay Year
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Records,	e las has	Completed						autops perform	ned? d	eath?	sy findings available pletion of cause of
a	icien: Th certificate rector, pag	e Co	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 ath (Check only on	<b>Y</b>	Yes 2	:LI NO
of Vital		0	evaminer?	Hospital: 1 Inpatient 2	] ER/Outpatie	nt 3 DOA Ot		dome 5 ☐ Reside		or (Specify)	
on of	fe file	tion; To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju		28d. Describe ho			
Division	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification;	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e Place of Injury - At home, farm, street, factory, office 28f. Location					ion (Street and Number or Rural Route Number, r Town, State)		
) _	Hospitei 24 hours Funerel tely filled	edical Co	29a. Certifier (Check only one)  29a. Certifying Phy 2   Middical Exami	sician: To the best of my kn ner; On the basis of examin and manner stated.	owledge, dea ation and/or ir	th occurred at the to	ime, date and place opinion, death occ	e, and due to the caurred at the time, da	ause(s) and mar ate and place, a	nner as sta and due to t	ted. the cause(s)
	o the ithin 2 o the o the omple	Med	29b. Signature and title of certifier	and marrier stated.		29c. Licen	se number	2	9d. Date signed	(Month, D	ay, Year)
	Ø 4 € 4			•			2570%	18	(XI-	20-0	H
	3		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type		TE 201 A	ALALIADOI	15 MG	) 21	401
	K-1		AT Date flor (Month Cont Your)	32 Registrar's Sign	JUSEL	TIVES	E 231 A	MINITO	10 11 11	, 01	V
	St Regist	ate trar	31. Date filed (Month, Day, Year) SEP 2 2 200		& A	BAR.					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 03:08 AM DUBOW September HARRIET 17,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNION MEMORIAL HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) SEPT.8,1937 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☐ F 67 MD Director 217-34-8556 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show 27 is marked other then "natural", or items 23a or 28a-f ebor traumatic evant, the Medical Examinar must be mutilised at 1 ☐ Yes 2 No Director MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3726 BRENTFORD ROAD 21133 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or item any injury or other traumatic event, the Mental and Once. 1 ☐ Yes 2 ▼ No If Yes, Give 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: À WHITE 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** SINAI HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ASKIN GOODMAN ALBERT LEAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACK DUBOW / HUSBAND 3726 BRENTFORD ROAD - RANDALLSTOWN, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State VETERANS CEMETERY 9/20/2004 OWINGS MILLS, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pulmonery disease or condition resulting in death) edema /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): of Vital Records, P.O. Box 68760 attending physician the death certificate be Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Year Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗱 No 2 B No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 2 No 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 **M**Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M OAT2438946- E6 September, 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Butimore, MO 21218-2895 East University Purkway 201 Esmaili 31. Date filed (Month, Day Par) 2 ji kar's Signature 2 State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

		•	1- State of Maryland / Dep	artment of Health and Martificate of Death	, ,	iene .g. R. () () L	29927	
			Decedent's Name (First, Middle, Last)		2. Date of Deat	Death 3. Time of		
	Physicia		Robert Weston Emerson		Month	Day Yeer	10:00 a M	
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	h			
1	_xuiiiii		Stella Maris Hospice @ Mercy Hospital	Baltimore		N/A		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth (Month, Day,		nplace (State or Foreign untry)	
	Director		021-36-2978 1 XM 2□F 58 Yrs.	Monard Bayo Hodis Mini	Oct. 4,		aine	
	pu >	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits	
	sho	5					1 ☐ Yes 2X No	
	the N	Director	Ma Norfolk Quinc	10f. Zip Code	10	0g. Citizen of What Co	untry?	
	a or			02169	"	USA	y.	
	eath	Funeral	10 Weston Avenue Unit 212  11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	rican Indian,	
10	fter d	듄	Armed Forces?  1 Never Married 2 Married 1 Sec. No. 11 Yes, Give		Rican, etc.)	Black, White		
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21	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)				
7	ed wi	Co		le Clerk		Federal Gov	vernment	
, E	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam		,		
\\ \frac{1}{3}	ould Men marke	은	Eliot Putnam Emerson	Florence Flo	ce Edna I		To Co do)	
Maryland 21215-0036	12 st h and 7 Is n traun							
	1 and Health em 2		20a Method of Disposition 20b. Place of Disp	Southwick Street I		VIT INLA 2 20c. Location - City or		
ام ک	ages nt of 1		1 ☐ Burial 2 「VCremation 3 ☐ Removal from State cemetery, cr	ematory or other place)				
Saltimore,	it. Partmenturant			rematory Inc. 09/2			e, Maryland	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel; or Items 23a or 28e-f show any injury or other traumetic avant, Item Medical Examinations to be notified at Once.		Thomas Greger	remation society ( 299 Frederick Road	Baltimo	<u>re Marylan</u>		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	ongoputhy			Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):					
	Examine		Sequentially list conditions, b					
	ed is	ine	fany, leading to immediate cause. Enter Underlying Cause (Ulsase of High.)					
	and and	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):					
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687	ficate phys s the	edicai	d					
Вох	eath certific attending p	Ž.	IF FEMALE: 23c. If yes, outcome of pregnancy	Co VIV. NOT C. II		23d. Date of del	very	
ă	that the death cer ed by the attendir detached for use	cia	in the past 12 months?  1 Vos. 3 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year	
P.O.	t the di by the tached	hys	9 Unknown					
σ.	Physicien: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?	
Ę	quire on sig uld b	ed b			1 □ Ye	as 2□No 3□Pr	obably 4 Unknown	
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ta	ician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Deat	h (Check only on			
>	Physici this ce al direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpati	ent 3 DOA Other: 4 Nursing Ho	ome 5 Reside	ence 6-Dother (Spec	in hospice	
0	Jing PI		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury		28d. Describe ho	w injury occurred		
\ <u>\o</u>	Attanding it death.	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No				
Division	or Att ter de irect	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,	
	urs af rral D							
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 ☐ Certifying Physicien: To the best of my knowledge, der (Check only one) 2 ☐ Medicel Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	to the cause(s)	
	o the o the omple	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Monti	n, Day, Year)	
	F > F 0		by they mo	NUNESH		9/21/	2004	
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	a, Print)				
	,		David Riseberg 301 ST F	CULPL BOIL	more v	nd 21	202	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1.4.				
	Regist	rar	SEP 2 2 2004 Busines &	port				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 20020 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 19, Year September 19,2004 **Physician** 3:00 P Anita K. Frederick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Joseph Richey Hospice Baltimore | If Under 1 Year | If Under 24 Hrs. | S. Date of Birth (Month, Day Year) | Nov. 27, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1□M 2ÅF Maryland Yrs. 86 220-07-4717 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore 1.☐Yes 2 ☐ No Maryland N/A Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 United States 601 S. Macon Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1□ Yes 2□XNo Specify: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Distillery 9 yrs Production Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fil Health and Mental H tem 27 is marked ott Marie Reuter Irvin Krause 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 103 Center Place # 211 Dundalk, Maryland 21222 Michael Krause/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X☐Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/21/2004 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 lasse 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) brees Physician Cancor of the bonz 5 yeres /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of). Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Øunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospice examiner Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No funeral c 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō within 24 hours a

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completely filled i 29a. Certifier 🕊 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Rolle B. Jing M. D. 5 212000 B 9-19.0 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h TELL Winards Rock Ruliniform, My 21137 Porf. B. FENN 31. Date filed (Month, Pay, Year) SEP 2 2 2004 State Elen & Spall Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Rosene Fisher September 18, 2004 12:02 P M /Medical 4c. County of Death 4b, City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2፟\F 77 Yrs. 1926 124-14-6117 New York Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show r than "naturel", or Items 23e or 28e-f show the Modical Exporter outst be notified at 1 ☐ Yes 2X No Directo Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4400 East West Highway #1008 20814 United States death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or5+) Department Store Sales Associate 12 i. Pages 1 and 2 should be filed vitment of Health and Mental Hygie tent: If item 27 is marked other to jury or other treumetic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rose Ferrare Leo Vaccaro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 50 North Allen Street, Albany, New York 12203 Harrison M. Fisher/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Sept. 21, 2004 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Montgomery Crematorium Bethesda, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): **Examiner** Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the at id be detached fo 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes 2X No Division of Vital Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide Hospitel within 24 hours a 29a. Certifier 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro the certifier 29c. License number 29d. Date signed (Month, Day, Year) title q 29b. Signature BR8777495 September 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 9901 Medical Center Drive, Rockville, Maryland 20850 Atul Rohatgi, M.D. 31. Date filed (Month Bay 2 2 2004 State Registra

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Examin	er	4a. Facility Name (If not institution, g				BAL	TIMO	RE				N/A		
Funeral Director		5. Social Security Number 212-56-3715	Sex M ZKIF 7	. Age ( <i>In yr</i> s. <b>54</b>		If Under Months	1 Year Days	If Under Hours		te of Birth 17/194	( <b>9</b> <sup>ar)</sup>	. Birthplace (State Country) GERI	or Foreign MANY	
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with the a or 28	Director	13 RICHARDS GREEN COURT					10f. Zip Code 21117					10g. Citizen of What Country?		
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Physician		23a. Part1 Enter he disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	omplications that cannot be a second and a secon	used the deat ich line.	th. Do not en	ter the mod	e of dyin	g, such as	cardiac or respi	iratory arres	it.	Approxima Interval Be Onset and	etween	
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Physician: The this etilicate har all di ector, page	Be	25. Was case referred to medical examiner?	Hospital:	patient 2	] ER/Outpatie	nt 3□ DC	Oth	or		e of Death (Check only one)				
ding Phys h. After this funeral di	tion; To	27. Manner of Death 1 Statural 5 Pending	28a. Date of (Montal	f Injury h, Day Year)	28b. Time of Injury	Time of 28c. Injury at 28d. Describe how injury occurre								
Hospital or Attending 14 hours after death. Funeral Director: Attentely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not determine	of Injury - At h	njury - At home, farm, street, factory, office 28f. Locatio					on (Street and Number or Rural Route Number, Town, State)					
To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edicai C		Physicien: To the xaminer: On the ba and mann	isis of examina	ation and/or in	rvestigation	, in my o	pinion, dea	ath occurred at the	he time, dat	e and place, an	d due to the cause	(s)	
To the within 2 To the complet	Me	29b. Signature and title of certifier	Doell	la -		290	c. Licens	e number	67	29·	d. Date signed (	Month. Day, Year) ber 16, Ho. 172	2004	
6		30. Name and address of person v	ho completed caus	e of death (Ite	m 23a) (Type	. Print)	W.	Be la	vedera	2 Au	E, B	40 Md	2/2/	
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 2 2	2004	egistrar's Sign	ature	sele!								

	1	FOR	partment of Health and M Pertificate of Death	ental Hygien	2001. 2002t			
Physicia	n	Decedent's Name (First, Middle, Last)     HENRIETTA	FREED	2. Date of Death Month D. September	3. Time of Death 7:18 A M			
/Medic	er	4a. Fecility Name (If not institution, give street and number)  Sinai Hospital of Baltimo  5. Social Security Number 6. Sex 7. Age (In yrs. last birtha	ay) If Under 1 Year If Under 24 Hrs.		c. County of Death  N/A  9. Birthplace (State or Foreign			
Funeral Director		214-20-3600 1 M 2 T F 77 Yrs  Usual Residence of Decedent	Months   Davs   Hours   Min.	JULY 28, 1	1927 Country) TEXAS			
Maryland -f show led at	tor	10a. State         10b. County         10c. City, Town of BALTIMORE	r Location _TIMORE		10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
with the ta or 28a	Director	10e. Street and Number 1115 SCOTTS HILL DRIVE	10f. Zip Code 21208	10g. C	itizen of What Country?			
s after death	by Funeral		13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🂢 No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE			
IND X IX IS-UUSO  be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland d other than "natural", or terms 23a or 28a-f show event, the Madicul Eventiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  [College (1-407.5+)]	ecedent's Usual Occupation live kind of work done during most of worki fe. DO NOT use retired) MEMAKER	ng 16b.	16b. Kind of Business/Industry  OWN HOME			
V 0 5 5	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maide	n Surname) L. KRIS			
Maryland d 2 should be file th and Mental Hy. ?? is marked othe traumatic event.	၉	19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Rura					
Item Stan	1 )	20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition 3   Removal from State		Date 20c.	Location - City or Town, State  BALTIMORE, MD			
baltimo permit. Page Department of Important: if any injury or		21. Signature of Funeral Service License	22. Name and Address of Facility SOL 8900 REISTERSTUWN I					
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of)	vooculor Acc	-1	Approximate Interval Between Onset and Death			
od / oU, toate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of)  c. Due to (or as a consequence of)						
death certif	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnent at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year			
<b>ග්</b> සි සි බ	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to						
4 G G CI	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes XNo			
of Vita Physician: rthis certifica ral director, r	To Be C	25. Was case referred to medical examiner?  1  Yes	Other	me 5 Residence	6 ☐Other (Specify)			
DIVISION OF VITAL HE To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification; T	27 Manner of Death 28a. Date of Injury 28b. Tir	ury Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred  and Number or Rural Route Number,			
DIVI.		4 ☐ Homicide determined building, etc. (Specify)		City or Town, Sta	ite)			
To the Hospital of within 24 hours a To the Funeral Completely filled it	Medical	(Check only 2 Medical Examiner: On the basis of examination and one)	openin occurred at the time, date and place, or investigation, in my opinion, death occur	red at the time, date a	nd place, and due to the cause(s)  Date signed (Month, Day, Year)			
§ 5 <u>₹</u> 5		29b. Signature and title of certifier  Ledy Julia Di Marsia	MD D00612		ptember 16, 2004			
4		30. Name and addless of person who completed cause of death (Item 23a) (The Ledy's Dimarsico, MD 25 Main	ype, Print) Street Riesterstow	n mo	21136			
Sta Regist		Ledys Dimarsico, MD 25 Main  31. Date filed (Month, Day, Year)  SEP 2 2 2004  Sep 2 2 2004	book					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** B 2004 ALBERT JOSEPH FIERSUK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner ANNE ARUNDEL CLEN BURNIE NORTH ARUNDEL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 12/16/1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral XX**M 2□ F 80 MARYLAND Director 218-14-2712 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other than "natural", or items 23a or 28e-f shov treumatic event, its Medical Examinar must be notified all NORTH LINTHICUM 1 ☐Yes 2XXNo ANNE ARUNDEL MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 U.S.A. 6872 B & A BLVD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married XX Married 1 ☐ Yes XX No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) KOPPERS CO. MACHINE OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental KATIE KAZLA JACOB FIERSUK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) EDITH MAY FIERSUK - WIFE 6872 B & A BLVD., NORTH LINTHICUM, MD 21090 Department of Health Importent: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/21/2004 GLEN BURNIE, MD GLEN HAVEN MEM. PARK 22. Name and Address of Facility FINK FUNERAL HOME, PA 21. Signature of Funeral Secretal Licensee 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 FINK #MO1148 GREGORY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chepo youndar Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner ren morn Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examine certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 TYes 2 No Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 5 within 24 hours a To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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Baltimore,

Box 68760,

o.

Division of Vital Records,

erson who completed cause of death (Item 23a) (T

			1 - For State Registrar	State o	f Marylar		artment <i>tificate</i>			and M	lental Hy	/gien Rag. N	0001	200	20
			1. Decedent's Name (First, Midd	fle, Last)							2. Date of D	eath	-	3. Time of D	Death
	Physic /Medi		Katherine	Agatha	(	Granrut	-h				Month Septem		<sup>ay</sup> Year 19, 200	4 2:34	M
	Exami		4a. Facility Name (If not institution			JEQIH QI	4b. City, To	own, or l	Location or	f Death	<u>pehreum</u>		County of Dea		pm
P.S.			4019 Baker Lan	ne			Perr	v Ha	11				Baltimo		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under 2		8. Date of Bi	rth			Foreign
L	Director		218-28-7307	1 □ M 2 1 F	71	Yrs.	Months	Days	Hours	Min.	1/25/	ay, Year 1933	Ma	rthplace (State or lountry) ryland	
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	anyla show	3	10a. State 10b. County	у	10c. Cit	ty, Town or Lo	cation							10d. Inside City	Limits
	Ba-1	cto	Maryland Balti	more	Pe	erry Ha	11							1 ☐ Yes 2	No No
	or 2	Director	10e. Street and Number				10f. Zip C	ode				10g. C	tizen of What C	ountry?	
	ath w	2	4019 Baker Lan	ie			212.	36				U.	S. A.		
	r de	Funeral	11. Marital Status	Amed For	dent Ever in U.	.S. 13. V	Vas Deceder Yes, specifi	nt of His	panic Orig	in? (Spe	cify Yes or No Rican, etc.)		14. Race - Am Black, Whi		
36	or l	by Fi	1 Never Married 2 Mar	If Yes, Giv	0		☐ Yes 20		Specify:				Specify:	16, 610.	
00	hour ural	d b	3 Widowed 4 Divorced		ates:				21				W	nite	
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Itams 23s or 28s-f show event, the Medical Examination in the Legislaria	Completed	(Specify only highe	nt's Education est grade completed)		(Give	lent's Usual ( kind of work	done du	tion <i>Iring</i> most	of worki	ng		(ind of Business	Industry  County I	D00.20
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Maryland	12 s har 7 ls trau			( H	usband	1)							or Town, State,		
	1 an Heal am 2 thar	1 3	Harry Albert G  20a. Method of Disposition	ranruth, J		4019	Baker	Lan	e Pe		Hall,		yland 2		
Š			1 Burial 2 □ Cremation		State	emetery, crem	atory or othe	er place)	1	9/	24	20c. L	ocation - City or	Iown, State	
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licensee	,,	Br.	Name and in	Address ISKi	of Facility	ral	Home F	Δ			
	TO 2 # 0		Michael	1. Jash	ner 500	14	OTO A	ı La	steri	1 AV	enue 1	isse	x, Mary	land 2122	21
P.			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that ca t only one cause on ea	used the death ach line.	n. Do not ente	or the mode o	of dying,	such as c	ardiac o	r respiratory a	rrest,		Approximate Interval Betwe	
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Вох	attending for use a	ian,	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Fetal	death 3 🗆	Ectopic preg						23d. Date of del Month	ivery Day Yea	
o.		/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregna 9☐ Unkno	int at time of de wn	eath 5□	Other (speci	ify)					WOITH	Day 19a	П
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U	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	28c.	Injury a Work?	t	2	8d. Describe h	now injur	y occurred		
sio	ittandi death. ctor: A / the fu	catl	2 Accident investig	gation			М		s 2 No	0					
Division	i or At after d Diract J in by	Certification:	4 Homicide determ	lined 286. Place (	of Injury - At hor g, etc. (Specify	me, farm, stre	et, factory, of	ffice		2	8f. Location (S City or Tow	Street an In, State	d Number or Ru )	ral Route Number	5
	ospital hours a uneral C		-	1						1					
	B Hosp 24 ho 8 Fune Stely fi	ca	Corrock only 2 Intedical	ng Physician: To the t Examiner: On the bas	sis of examinati	wledge, death ion and/or inve	occurred at t	he time, my opin	date and	place, ar	nd due to the o	cause(s)	and manner as	stated.	
	To the Hospital or Attanding within 24 hours after death.  To the Funeral Diractor: After completely filled in by the fune	Medical	one) 29b. Signature and title of certifier	and manne	er stated.										
	F 3ES	_	255. Signature and little of certifier	11 (1)	).	Q.M	29C. L	icense n	lumber	11		عاظ. Dat	e signed (Month	n, vay, Year)	
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			30. Name and address of person	1/1 - 11.9	of death (Item		(1)	AL	0	1 1	14	λ,	144	A 210	7/
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3	Registr	ar	31. Date filed (Month, Day, Year)	2 2004	mus.	K A	all .								

State of Maryland / Department of Health and Mental Hygiene

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retin.			332 HORNEL	ST				BALTIA		r	ı/a	
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	pu &	ŀ	Usual Residence of Decedent  10a. Stete 10b. County		10c. City	, Town or Loc	ation				1	Od. Inside City Limits
	the Maryler 28a-f show notified at	5	Md. n/a		P	altim	ore				İ	Yos 2 ☐ No
	28a	2	10e. Street end Number			are in	10f. Zip Coo	le		10g. Citizen of	What Coun	itry?
	3a or	٥	332 Hornel	Street			2	1224		US	SA	
Maryland 21215-0020	urs e	by Fur	11. Marital Status 1 □ Never Married ②⑤ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 XYes 2 ☐ If Yes, Give Year or Dates:	No .	I 1	□Yes 20Xi	of Hispanic Origin? (S Cuban, Mexicen, Puert No <i>Specity:</i>		Bla	e - Americ ck, White, Whi	etc.
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	the e	Physician/	Part Ii. Other significent conditions of	ontributing to death t	out not resu	Iting in the un	derlying cause	given in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
9.									1 🗆	Yes 2 No	3 ☐ Prob	sabty 4 Unknown
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Division of Vital Records,	or At free of Nreci in by	Certification:	4 ☐ Homicide determined	286. Piece of in	ic. (Specify	me, rarm, stre	et, factory, offi	ce	City or To		or or riora	House Halliber,
_	ours a	2	29a. Certifier 1 Certifying Ph	reieles. To the best	of my know	vledge death	occurred at the	e time, date and place	and due to the	cause(s) and ma	nner as et	eted
	To the Hospital or Attanding Phys within 24 hours after death.  To the Funersi Director: After this completaly filled in by the funerel director.	edicai			f examinati			ny opinion, death occu				
	vithin of the omple		29b. Signature and title of certifier	,	1		29c. Lic	ense number		29d. Date signe	d (Month, L	Day, Year)
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	1	1	30. Name and address of verson who	completed cause of	leath /Ita-	23a) (Tune 5						
	り		JENNIFER HAYASHI	MIN 5		ADKINE	BAVIII	EW CIRCLE,	RAINMI	RF NIN	717	24
	C Ctat		31. Date filed (Month, Day, Year)	32. Regist	rer's Signat	ure _	MIVI	EN CINCIE	UTCITING	The IVID	ox l ox	× 7
	State Registra	_	SED 9 9 200A	henerte	B	Los	u Kal					

			For State Registrar	State of	Maryland / De	epartment of I Certificate of			iene	in change	20025
	Physici	an	1. Decedent's Name (First, Middle,		GR	1		2. Date of Dear Month	th Day	Year	3. Time of Death
-	/Medic	al	RUSSE  4a. Facility Name (If not institution,		- (		or Location of Deat	09_	14 20 4c. County of	04 of Death	9:45p M
	Examin	ier	509 Roundview		,	Baltin			,		
	Funeral Director		5. Social Security Number 248–24–7822		Age (In yrs. last birth	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day)	, Year)	9. Birthp Coun	lace (State or Foreign try) SC
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				1	0d. Inside City Limits
	death with the Maryland ms 23e or 28e-f ehow	ctor	MD NA		Balt	imore					1 ∑Yes 2 ☐ No
	vith the	Funeral Director	10e. Street and Number	_		10f. Zip Code	2205	1	0g. Citizen of W		itry?
	leath v	eral	509 Roundview	12. Was Decede	ent Ever in U.S.	13. Was Decedent of If Yes, specify Cub	21225 Hispanic Origin? (S	pecify Yes or No-	14. Race		ean Indian,
920	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other then "neturet", or items 23e or 28e-f ehow or other treumetic event. It is Madical Exactinations the notified at	by	1 Never Married 3 Marrie 3 Widowed 4 Divorced	Armed Force	es?	If Yes, specify Cub  1 ☐ Yes 2X No		o Rican, etc.)	Black Specify:	., White, ${ m B}{f 1}$	etc. ack
2	72 ho	eted	15. Decedent (Specify only highes		(6	ecedent's Usual Occu	during most of war	rking	16b. Kind of Bus	iness/Ind	dustry
21215-0036	within and the street with the	Completed	Elementary/Secondary (0-12) 6th grade	College (1-4	05 5 1)	te. DO NOT use retire to Shop (	. '		Body	and	Fender
g 2	be filed stal Hygi of other event, I	BeC	17. Father's Name (First, Middle, L				18. Mother's Nar	me (First, Middle, I	Ma <i>iden S</i> umame	)	<del></del>
Maryland	should band Ments marked	일	Christopher G		40). 4	Mailing Address (Stree		e Willi		24-4- 77-	0-4-1
Mar	id 2 sh th and 27 Is n treun		19a. Informant's Name/Relationship			9 Roundvi					21225
re,	es 1 and 3 of Health f Item 27 r other tr		20a. Method of Disposition		20b. Place of D	risposition (Name of crematory or other pla			20c. Location - (		
Baltimore,	Pages ment of lent: If It		1 🌠 Burial 2 □ Cremation '4 □ Donation 5 □ Other (Sp	necify)	Garris	on Forest		127/04	Owings	Mi	lls, Md
Ball	permit. Pages Department of Importent: If I eny Injury or once.		21. Signatury of Funeral Service L	C. Tru	1 pt	22. Name and Addr March F/I 4300 Waba	H West ash Ave.	Baltin	nore, M	ld	21215
ı			3a. art1. Enter the disease, or shock, or heart failure. List of	complications that can only one cause on eac	ised the death. Do no	t enter the mode of dy	ng, such as cardia	or respiratory arm	est,	nd-1	Approximate Interval Between Onset and Death
7	Pnysician /Medical		Immediate Cause (Final sease or condition resulting in death)	a. Due to (or	s a consequence of		Carr	Cost	Cos	4	2 maly
	Examiner		Sequentially list conditions	b. ———							
	ed sit	Iner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of						
	sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of	;					
8760,	cate be ex ohysician the burial			d							
9	eath certificate be executed attending physician and for use as the burial-transit	/Med	IF FEMALE:	23c. If yes, outco	me of pregnancy				23d. Date	of dollars	
O. Box	death e atter	hysician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birt	h 2 Fetal death It at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey .		Mont		Day Year
ds, P.	es be	by P	Part II. Other significant condition	ns contributing to dea	th but not resulting in t	ne underlying cause gi	ven in Part I.	23e. Did tot	51		ne cause of death? ably 4 Unknown
Vital Record	a ¥s S	ompleted						24a. Was a			psy findings available inpletion of cause of
Ä	The ate h page	Com						perform	ned? de	ath? Yes	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	0 T F D (0 )	Ot	har	ath (Check only on			
of	iding Physith. Ih. After this funeral di	n; To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	natient 2 ☐ ER/Outp Injury 28b. Tir Day Year) Inj	ne of 28c. Inju	4 🗆 Nursing r	28d. Pescribe ho	ence 6 Other ow injury occurre		/)
sion	Attending ir death. ector: After by the fune	catlo	Natural 5 Pending Accident investig	ation	bay roary my	*	Yes 2 □No				
Division	of or Attency after death	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		f Injury - At home, farn i, etc. (Specify)	n, street, factory, office	-	28f. Location (St City or Town	reet and Numbe n, State)	r o <i>r Rur</i> a	l Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier Certifyin (Check only one)	g Physician: To the b Examiner: On the bas and manne	is of examination and/	death occurred at the to investigation, in my	ime, date and place opinion, death occu	e, and due to the caurred at the time, do	ause(s) and man ate and place, ar	ner as st nd due to	ated. the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	to No	J-1	29c. Licen	se number	4/ 57	9d. Date signed	(Month,	Day, Year)
	NXI		30. Name and address of person	who completed cause	of death (Item 23a) (T	(pe, Print) 30	S. 10	Har	love	Y 5	street
	Sta	ate	31. Date filed (Month, Car, Year)	2 2004 32. Rg	istrar's Signature	had.	salt	hour	V	D	41225
	Regist		SEP 4	₩ ZUU4	WELL ST	7					

			Please	Type or Print in i					-	_	
			1 - For State Registrar	State of Marylar				wen	itai Hygie	ene	00006
					Ce	πirical	e of Death	1 .		. No.	53736
	Physicia /Medic		1. Decedent's Name (First, Middle, La DEMIETRUS	DANIELS	GH	455	AWAY		Date of Death	Day Year.	3. Time of Death 3:20A M
-	Examin		4a. Facility Name (If not institution, girls So. MD. HOSPIT	and the same of th		1	Town, or Location of De STON, MI			4c. County of Deatl	GEADLE
	\			AL CENTER  7. Age (In yrs.	last hirthday	_	1 Year If Under 24 H		Date of Birth	PRINCE	DEURGES
	Funeral Director			7. Age (In yrs.	Yrs.	Months	Days Hours Mi	[] G	Date of Birth Month, Day, Y	-04 m	nplace (State or Foreign untry) ARYLAND
yland	WOL.		10a. State 10b. County	10c. Ci	ty, Town or L	ocation	. /				10d. Inside City Limits
не Маг	88-18 cuiffind	ector	MD. PRINCE	GEORGES 1	HOKT	WAS	HINGTON CODE		100	. Citizen of What Co	1 Yes 2 No
ING ZIZIS-UUSO be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or items 23a or 28e-f show important: If Item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, It a Medical Examination mast be notified at once.	Funeral Director	10e. Street and Number  920 PALME	R- RD. +	t6.	101. 21	20744		109	U,S	å
dea	ams ar an	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Dece	dent of Hispanic Origin? cify Cuban, Mexican, Pu	(Specify erto Rica	Yes or No- n, etc.)	14. Race - Amer Black, White	
rs after	l', or its	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1		1 🗆 Yes			,		LACK.
P Por	atura	ed	15. Decedent's E	ducation	16a. Dece	edent's Usu	al Occupation		16	ib, Kind of Business/l	
ZIZIO-CUSO ed within 72 hours af	e. Medii	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	life.	DO NOT u	ork done during most of wase retired)	vorking			
N be	Hygiene. other than	S	NONE		none					none	
<b>1</b>	d of	To Be	17. Father's Name (First, Middle, Las	")			18. Mothers N	iame (Fil	_	iden Sumame)	. 4.1
should	Ment varke vatic e	၉	NONE	T = 0.10	401 14-33	G. Kana	DEMET	KIA		GASSAU	
CV.	th and 7 is mu traum		19a. Informant's Name/Relationship	OFTRIA	920	PAI	(Street and Number or i	#/	FT. 1	DASH M	20744
1 and	Heal tem 2 other		20a. Method of Disposition	20b. i	Place of Disp	osition (Na.	me of	Date	20	c. Location - City or	Town, State
Pages	nent of int: If I		1 ☐ Burial 2 ☐ Cremation 3 [ '4 ☐ Donation 5 🖔 Other (Special Control of Co	JHemoval from State	cemetery, cre	matory or t	other place)				
permit. Pages 1 ar	Department of Health Important: If Item 27 any injury or other trees.		21. Signature Funeral Service Lice Ron Id S	Wade, Drecto	r Si	tate.	nd Address of Facility Anatomy Boar ore, MD 212		55 W. B	altimore	Street
			23a. Partil. Enter the disease, or con	plications that caused the dea					spiratory arrest	i.	Approximate Interval Between
100	ysician	0. 1	shock, or heart failure. List only Immediate Cause (Final	20 CM	k2.	2101	ation -	na	700	Ale	Onset and Death
/	Medical		disease or condition resulting in death)	a. Due to (or as a consec	7.7	, Dec	aury 0	100	Keta		
E	aminer		S-puentially list conditions,	b	V				of the	~~	
pe	ısit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence ot <sub>j</sub> .						
be executed	and al-tran	xan	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):						
	physician and s the burial-transit	calE		d							
ificat	g phy as the	edic									
DOX 00 auth certificat	esu use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1□Live birth 2□Feta		⊒Ectopic p	regnancy			23d. Date of deli	•
	igned by the attending phy be detached for use as th	Physician/Medi	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of o		Other (s				Month	Day Year
that the d	ed by detac	, Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the u	underlying o	cause given in Part I.	Ī	23e. Did tobac	co use contribute to	the cause of death?
duires ,	n sign ald blu	d by						-	1 🗆 Yes	2×No 3 □ Pro	bably 4 Unknown
S %	as been si 2 should l	Completed							24a. Was an autopsy	24b. Were au	opsy findings available ompletion of cause of
The		шо							performe	d? death? No 1 ☐ Yes	20 No
in in	rtifica tor. p	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Ch	eck only one)		
nysic	this ce al direc	To	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ D	OA Other: 4 Nursing	Home	5 Residence	e 6 □Other (Spec	ify)
5 E	h. After ti funera		27. Manner of Seath 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		28c. Injury at Work?	28d.	Describe how	injury occurred	
tend 5	leath.	cati	2 Accident investigated 3 Suicide 6 Could not i			M	1 ☐ Yes 2 ☐ No	206	conting /Street	at and Number or Du	m I Pouto Alumber
Livision of vital necolus,	after deatl Director: I in by the	Certification;	4 Homicide		fy)	reet, factor	у, опісе	201.	City or Town, S	et and Number or Ru. State)	al noute Number,
To the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this certificate the completely filled in by the funeral director, page	edical C	(Check only 2 Medical Exa	hysicien: To the best of my knominer: On the basis of examina	owledge, deat ation and/or in	th occurred	at the time, date and pla , in my opinion, death oc	ce, and c	due to the caus t the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
the	thin 2 o the mplet	Med	29b. Signature and title of certifier	and manner stated.		29	c. License number		29d.	. Date signed (Month	Day, Year)
70	≥ S		All men	J. 200 S.		7	124302			9-8-1	54
			30. Name and address of person who	completed cause of death (Itel	m 23a) (Type	Print)	יסטלו כל	-	. 1	/ 0 0	
			JOSEPHINE VI	ERGARA 1	503	SUR	RATTS RD	C	UNTO	W. MD o	20735.
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature						
	Registr	ar	SEP 2 2 200	4 Ellever St	dea	de					

ĺ			State of Maryland / Department of Health and Mental Hygiene  State Registrar  Certificate of Death  Reg. No. () () () () () () () () () () () () ()
1	Physici		1. Decedent's Name (First, Middle, Last)  Clarence  2. Date of Death Month Day Year 09 11 2004 01:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death
	Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 52 Yrs.  7. Age (In yrs. last birthday) Months Days Hours Min.  1 M 2 F 52 Yrs.  1 M 3 F 52 Yrs.  1 M 3 F 52 Yrs.  1 M 3 F 52 Yrs.  1 M 3 F 52 Yrs.  1 M 3 F 52 Yrs.  1 M 3 F 52 Yrs.  1 M 3 F 53 Yrs.  1 M 3 F 53 Yrs.  1 M 3 F 54 Yrs.  1 M 3 F 54 Yrs.  1 M 3 F 54 Yrs.  1 M 3 F 55 Yrs.  1
	show	٦٢	Usual Residence of Decedent         10e. County         10c. City, Town or Location         10d. Inside City Limits           MD         Anne Arundel         Annapolis         1 □ Yes 2√ No
	28a-f	recto	MD Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country?
	h with	ID IE	1778 Abel Drive 21401 USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23c or 28a-f show important: if item 27 is marked other than "natural", or Items 23c or 28a-f show any injury or other traumatic event, I've Medical Evantian frault to notified at an once.	by Funeral Director	11. Marital Status  1
21215-0036	hin 72 hou e. en "natural Medical E.	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
2	filed with Hygiene. Ither than		unk unk state of MD
land	should be filed nd Mental Hygi t marked other umatic event, I	To Be	17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk
, Maryland	and 2 shou ealth and N n 27 is ma		19a. Informant's Name/Relationship (Type, Print)  Good Samaritan Hospital  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  5601 Loch Raven Blvd Baltimore, MD 21239
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra once.		20a. Method of Disposition  1 Date  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State
Balt	permit. Departr Importa any inju		21. So Feneral Service Name and Address of Facility Board 655 W. Baltimore Street  Baltimore, MD 21201
	Dhuaisian		26a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final
)	Physician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of):  Solve to 4 the total of the to
	ed nsit	nlner	Sequentially, list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):
8760,	ate be executed thysicien and the burial-transit	Ical Examiner	cause Disease or injuly that initiated events resulting in death) Last  c. Sq Stolle Storage Free Consideration of the Consideration of
Ÿ.	artificat ing phy e as th		IF FEMALE:
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Records,	The law requate has been bage 2 should	Completed	Hyperlipideuig  Acute on Chronic Renal Failure  24a. Was an autopsy performed? performed? performed? In yes 2000 10 yes 2000 1
Vital	cian: ertifica ector, p	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
	ding Phystcian: The I h. After this certificate ha funeral director, page	on: To	1   Yes 2 No
Division of	or Attenititer deat Sirector: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edical Ce	29a. Certifier  (Check only one)  (Check only on
}	To the vithin To the complete	Me	29th Signature and title of Certifier  M.O.  29c. License number  29d. Date signed (Month, Day, Year)  08/1/2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Mejevoi 5601 Loch Raven Blud., Baltimore MD 21239
6	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 2 2004 32. Registrar's Signature

	hycinia		1. Decedent's Name (First, Middle, La	1 #1 PER PHY&20b PE	<del>**</del>	2. Date of Death Month	Day Year 050
	hysicia /Medic	al -	MARCY	4E3BA	O Town and all the		13 2001
	Examine	er	4a. Facility Name (If not institution, giv	A .	4b. City, Town, or Location		SATIMORE
	uneral rector		5. Social Security Number 6. S	For The Age (In yrs. last birthough 1 Age (In yrs. last birthough	(ay) If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date of Birth	Year 1908 9. Birthplace (State or Foreign MARY LAND
and	<b>*</b> _		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
72 hours after death with the Maryland	or 28a-f show	ctor	MD N/A		BALTIMORE		1 √ Yes 2 □ No
with t	a or 2 be or	E E	10e. Street and Number 2500 W. BELVEDERI	- ΔVF #205	10f. Zip Code 21215		USA
1000	rrust	nera	11. Marital Status		13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic		14. Race - American Indian, Black, White, etc.
	If Itam 27 is marked othar than "natural", or Items 23a or 28a-f shov or othar traumatic avant, I'ra Modical Examiner must be notified at	d by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 (X) No If Yes, Give Year or Dates:	1 ☐ Yes 2 🗖 No Specia	fy:	Specify: WHITE
4	"natu	letec	15. Decedent's E (Specify only highest gr	ade completed) (C	ecedent's Usual Occupation Give kind of work done during mi fe. DO NOT use retired)	ost of working	6b. Kind of Business/Industry
in mene	tran tran	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	00KKEEPER		STATE OF MARYLAND
Mantal Hvoi	marked othar than matic avant, the M	To Be C	17. Father's Name (First, Middle, Last DAVID	SACHS		ther's Name (First, Middle, N RACHAEL	LEVY
th and	27 is ma r trauma		19a. Informant's Name/Relationship SHERMAN GESBEN (		tailing Address (Street and Num E. 18TH ST., A	NDER OF RURAL ROUTE NUMBER, NPT. 2-E NEW	City or Town, State, Zip Code) YORK, NY 10003
Jes 1 an	If Itam 27 or othar to		20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Removal from State cemetery,	isposition (Name of crematory or other place)	9/19/2004 9/19/04	20c. Location - City or Town, State
t. Pag	rtant:		'4 ☐ Donation 5 ☐ Other (Speci	beir	TFILOH  22. Name and Address of Fac	9/19/04 SOL LEVINS	BALTIMORE, MD SON & BROS.,INC.
permi	Important: If Ital any injury or oth once.		21. Signature of Stineral Service Lie	Druger	8900 REISTERST	OWN RD., PIKE	SVILLE, MD 21208
			26a. Part1. Enter the disease, or con shock, or heart failure. List only	polications that caused the death. Do not one cause on each line.	enter the mode of dying, such	as cardiac or respiratory arre	st, Approximate Interval Between
-	sician		Immediate Cause (Final disease or condition resulting in death)	DE	MENT	TA	Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of)	:		
ecure	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	:		
поехе ед е	nysician he buria	Ical E					
TITICATE		ed	IF FEMALE:	3			
law requires that the death certificate	by the attending parached for use as t	Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
sthat	9 9	by Ph	Part II. Other significant conditions	contributing to death but not resulting in the	he underlying cause given in Pa	rt I. 23e. Did tob	acco use contribute to the cause of death?
94019	been sign should be					1 🗆 Ye	s 2 No 3 Probably 4 Winknown
a law re	nas be e 2 sh	Completed				24a. Was ar autops	prior to completion of cause of
n: Ihe	certificate has rector, page 2	e Cor	25. Was case referred to medical		ae Rie		No 1 Yes 20No
ysicia	is certific director,	To Be	examiner?	Hospital: 1 Anpatient 2 ER/Outp	Othor	Nursing Home 5 Reside	<u> </u>
ng Ph	fter th		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tin	ury Work?	28d. Describe ho	w injury occurred
or Attanding Physician:	To tha Funaral Diractor: Aft completely filled in by the fur	Certification:	Accident investigation  Suicide 6 Could not determine	be Ose Blees of Injury. At home loss	M 1 ☐ Yes 2 n, street, factory, office		eet and Number or Rural Route Number, , State)
8	Funaral etely filled	Medical C	29a. Certifier (Check only one) Certifying F	'hysicien: To the best of my knowledge, ominer: On the basis of examination and/ and manner stated.	death occurred at the time, date or investigation, in my opinion, o	and place, and due to the ca death occurred at the time, da	use(s) and manner as stated. ate and place, and due to the cause(s)
a Hosp		Φ	and Circums and title of contition	Λ ~ ^	29c. License numbe	er 29	d. Date signed (Month, Day, Year)
dsou Bull of	To the	Σ	29b. Signature and title of certifier	// 0 " () /	) ^ ~ ~	9 " / " 7 " "	Out of the same
To tha Hospital	To the	X	<b>)</b> (	completed cause of death (Item 23a) (Ti	ype, Print) NHC, SALT	1333 5	EPTEMBER 15, 200

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER" 17, 2004 10:45 P M **Physician GOLDMAN TERRI** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOWARD ELLICOTT CITY 8456 SPRING SHOWERS WAY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth FEB.8, 1968 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 1 □ M 2 🙀 F MD 36 255-47-6510 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c, City, Town or Location 10a. State 10h County r than "natural", or items 23a or 28e-f show the Medical Events at most be notified at 1 ☐ Yes 2 X No Director HOWARD ELLICOTT CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21043 8456 SPRING SHOWERS WAY filed within 72 hours efter death v Hygiene. sther than "natural", or items 23s Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗓 No 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U OF M COLLEGE PARK **ENGINEER** other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: if Item 27 is marked oth any injury or other traumatic event once. FISS CHERYL GOLDMAN BARRY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8456 SPRING SHOWERS WAY - ELLICOTT CITY, MD 21043 KARL REUSS / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 9/19/2004 REISTERSTOWN, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. re Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SRAIN METASTASES months Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner BREAST CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 24a. Was an autopsy 2 No Hospitel or Attending Physicien:
 24 hours after death.
 Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 □ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia Partway UXENT al 11065 Little 31. Date filed (Month, Day, Year) State 2 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U AMEND ITEM #18 PER FH G835 GPF 22964 9H Death 2. Date of Death Day 18 2004 Phýsician AR NEK AUL BEPTEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY ROCKVILLE HEBREW HOME OF GREATER WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. SEPT. 16, 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F **POLAND** 212-44-0281 83 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Itema 23s or 28s-f show other traumatic event, the Medical Exprimer must be traitined at 1 ☐ Yes 2 🕅 No BALTIMORE OWINGS MILLS Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 USA 4730 ATRIUM COURT Be Completed by Funeral filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No WHITE Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** GROCERY STORE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) if Health and Mental Item 27 is marked GARNEK CHANA HOLZMAN YITZCHAK CHAVA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 866 DIAMOND DRIVE - GAITHERSBURG, MD 20878 EVA GARNEK / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If It any injury or o CHEVRA AHAVAS CHESED 9/19/2004 RANDALLSTOWN, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Tolan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed buriai-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FRENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: page 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death. I Director: Af d in by the fur 1 🗌 Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certified SEPTEMBER 18, 2004 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Barbare, Kaluzhy, 6121 Montvose Road, Rockville, ND 20852 Kalazhi 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 2 State 2 2 2004 Registrar

	1	State of Maryland  1 - State Registrer		artment of Hertificate of E			iene •g. No. 0 0 4	29941
		Decedent's Name (First, Middle, Last)				2. Date of Deat Month	th Day Year	3. Time of Death
Physicia /Medica		Alice Julia Harrington				Septemb	er 20, 200	
Examine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Dea	th
		155 Grundy St., Apt 121  5. Social Security Number 6. Sex 7. Age (In yrs. la	st hirthday)	If Under 1 Year	ltimore If Under 24 Hrs.	8. Date of Birth	N/A 9. Bi	thplace (State or Foreign
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the M	ecto	Maryland N/A  10e. Street and Number		Baltim 10f. Zip Code	iore	1	0g. Citizen of What C	
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after or its	by Funeral Director	1 ☐ Never Married 2 M Married 1 ☐ Yes 2 M No			Specify:	, mount, orday	Specify:	
id 6 12 13-0030 filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or itama 23e or 28e-f show ent, it e Micalcal Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a Dece	dent's Usual Occupa	tion		16b, Kind of Business	White
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should be nd Mental marked c	၉	Vernon Deaver	405 14-70	- Add - (Charles		rie Sta	Ch , City or Town, State,	Tin Cordo)
Wider d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  Ralph O. Harrington (Spouse)						yland 21224
Heall Heall tem 2		20a. Method of Disposition 20b. Pla	ace of Dispo	osition (Name of matory or other place	, Apr. 12		20c. Location - City o	
Pages nent of int: if it ary or o		1 X Burial 2 Cremation 3 Removal from State		Mem. Park		/2004 1	Baltimore.	Maruland
DESILITIONS, INTERVICTION AT LATE 19-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or itama 23a or 28a-f show any injury or other traumatic event, it a Marylan Examiner must be notified at once.		21. Signature of Funeral Service Licensee					Funeral Ho	
0 88.5.58		Buin Ce Well	3	331 Bretun	s Lane, E	saltimor	e, Marykan	d 21213
1 2 10		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not en	ter the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
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OT VICAL Physicien: 1 rthis certificat ral director, pi	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 No  Hospital: 1 □ Inpatient 2 □ E	ER/Outpatie	nt 3□ DOA Othe	26. Place of Deat	9 4	ence 6 □Other (Sp	acify)
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pital o		29a. Certifier 124Certifying Physician: To the best of my know	viodae des	th occurred at the time	on date and place	and due to the c	ause/s) and manner a	s stated
DIVISION OF VITA  To the Hospital or Attending Physicien: within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Examiner: On the basis of examinatione)						
To the within To the	Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Mor	th, Day, Year)
		> 8V4 Sin	ren Sc	Alun	24576		9.20.0	20
n		30. Name and address of person who completed cause of death (Item			4.0	2.	2 2 34	
		31. Date filed (Month, Day, Year) 32. Registrar's Lignati	ure	Landan .	~~)	a	224	
Sta Registr		31. Date filed (Month Day, Year) SEP 2 2 2004	Lieu					

4a. Facility Name (If not institution, give street and number)

ST AGNES HEALTHCARE

/Medical

Examiner

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

BALTIMORE

iygiene	n	OI.	$\Box$	0	0	1
Reg. No:	U	UH	Car	J	3	L

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4c. County of Death

BATIMORE ND 21201

3. Time of Death

0729 A

Birthplace (State or Foreign Country)

2. Date of Death

SEPTEMBER 12 2004

	Funera Directo	_	5. Social Security Number 245-62-3361	6. Sex 7. A	ge (In yrs. last bir 63	Yrs. Months Day:		Mar 11, 1	9. Birthplace (Ste Country)	unk
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	Marylan s-f show	tor	MD 10a. State 10b. Co	unty	10c. City, Tow	m or Location Baltimore				le City Limits Yes 2 □ No
	Baltimore, Maryland 21215-0036  sermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  mportent: If item 27 is marked other than "naturel", or items 23s or 28s-1 show my injury or other treumatic event. Ite Modical Examinar court to confine countries and	Completed by Funeral Director	(Specify only h Elementary/Secondary (0-	unk  12. Was Deceden Armed Forces  Married 1 Yes 2 Ustreed 1 Yes, Give Year or Dates  adent's Education ighest grade completed)	No un	13. Was Decedent of If Yes, specify Cu  1 Yes 2 No.	21229 Hispanic Origin? (Speban, Maxican, Puerto lo Specify:  upation e during most of workii	ncify Yes or No-Rican, etc.)	USA  14. Race - American Indian Black, White, etc.  Specify: black  Kind of Business/Industry	unk
	re, Maryland 2121 s 1 and 2 should be filed within t Health and Mental Hygiene. item 27 is marked other than other treumatic event, the Man	To Be Con	unk 17. Father's Name (First, Mic	unk ddle, Last)		unk	18. Mother's Name	(First, Middle, Maide	ən Sumame)	unk
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	Balt permit. Departr Import	X	21. Signatur of Funeral Ser	vice Licensee	eccor	State Ana Baltimore	ress of Facility tomy Board _MD 21201	655 W. Ba	ltimore Stree	t
	The law requires that the death certificate be executed the has been signed by the attending physician and base 2 should be detached for use as the burial-transit of professional professi	Examiner	25a. Patt 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	line.	MMUNE or):			Approximents of the control of the c	Between and Death
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TCHAR	cords, P.O. Box 68760, wrequires that the death certificate be expeen signed by the attending physician should be detached for use as the burial	eted by	Part II. Other significant con	nditions contributing to death	but not resulting i	n the underlying cause o	iven in Part I.		o use contribute to the cause 2 No 3 Probably 4	Unknown
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HB	DIVI  To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		tifying Physician: To the bes dical Exeminer: On the basis and manners	of examination ar			ed at the time, date a	nd place, and due to the caus	
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			00 11	sees who completed cause of	doath (Itom 23a)	(Type Print)				

STREET

State Registrar

821 NORTH ENTAW

CEASAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 2001. Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:00 PM 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner paltimore HOSPItal Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Mari -22 1 □ M 2 0 F Director and Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 ☐ No Completed by Funeral Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 216 or Items 23a WMIN Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry ould be filed ...
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Department of Health at
Important: If item 27 Is
any injury or other trau Batto. Md. 21216 Niondawmi Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ed 4 □ Donation 5 □ Other (Specify) Hear 22. Name and Address of Facility ature of Funeral Service Licensee Home Funeral t Joseph Ave. 2222 W. North 23a. Pahl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 80,5 Immediate Cause (Final Priysician theumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of rany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à page 2 should be 1 Yes 2 No 3 Probably 4 Donknown Diebites Millits Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypr Kision has autopsy 2 No 1 Yes 1 Yes 2 No To the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ို 1 Yes 2 2 ER/Outpatient 3□ DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

Know as

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend item 24a per nurse g835 Cerifficate of Death 2006 Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 2004 6:45 AM thias ones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Examiner Baltimer If Under 24 Hrs. Joseph 5. Social Security Number Kiche more Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Linder 1 Year 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Hours Days 1 1 M 2 □ F 212-09-6682 87 Yrs. Director Usual Residence of Decedent 10a State 10b. County N/A 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Fiyes 2 □ No Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 21317 1806 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 2 N6 1 ☐ Yes 2 No Specify: ō Maryland 21215-0036 Specify: 131<u>ac</u> 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Menfal Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 8 +4 mar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kens Jones thias 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other pages 1) 31317 Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 24-04 4 ☐ Donation 5 ☐ Other (Specify) remortary 21. Signature of Furjeral Service Licen 22. Name and Address of Facility 1232 lid-Valley Dr. Jessup, PA18434 harch Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia **Physician** 3 weeks /Medical Due to (or as a consequence of): **Examiner** zheimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 D No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospi Le 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 TYes 2 □ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined. 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Medical Certification: To filled 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B2N Rached B. Levine 4940 Easten Ave. RM 235 Kachel B. Levine 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 21, 2004 **Physician** 7:46 Janicki Carolyn /Medical 4c. County of Dealh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) September 18,1934 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days Country, MD. Months 1 □ M 2 💆 F 70 Director 214-30-4602 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Iteme 23a or 28a-f show the Medical Examinational be notified at 1 ☐ Yes 2 No Md. Harford Belair Directo 10g. Cilizen of What Country? 10e. Street and Number 10f. Zip Code USA 21015 2237 Erin Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedenl's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own HOme Housewife 12 years es 1 and 2 should be filed vot Health and Mental Hygie of Health and Mental Hygie if Item 27 is marked other in other traumatic event, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Carolyn E. Carlisle George Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2237 Erin Way, Belair, Md. 21015 Husband Edward Janicki 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or oti September 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Sacred Heart Of Jesus Cem. 24, 2004 Dundalk, Md. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Momsema 1eous Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sa uential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at lime of death 5 Other (specify) 9 Unknown 9 Unknow ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 ther (Specify) NUSPICO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes • 2 ☐ No this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury courred Certification; After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Acciden s after death I Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital or within 24 hours a
To the Funeral I
completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check on one) and manner stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 21 2004 and address of person who completed cause of death (Item 23a) (Type, Print) horles St Rulfimore mo 21204 600 State Registrar

9/21/04

Carolyn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Lena Mae Johnson 70200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death oseda ank If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Aug. 13, 7. Age (In yrs. last birthday) 5. Social Security Number 1 ☐ M 2 💢 F Kentucky 82 407-20-6764 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Maryland N/ABaltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5062 Orville Avenue 21205 U. S. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Da **Physician** SARAH S. JONES 16,2004 Sept 4:05A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Forest Hill 2955 Grier Nursery Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/29/1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2□E Days Months Hours Yrs 76 Maryland 214-26-1214 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7.7 ia marked other than "natural", or Items 23a or 28a-f shov traumatic evant, the Medical Expertment that the couldist of Forest Hill 1 ☐ Yes 2 XXX Harford Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 USA 2955 Grier Nursery Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes AFT No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be ind Mental Mary Jenkins Walter W. Stansbury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2955 Grier Nursery Rd., Forest Hill, MD 21050 Samuel T. Jones- husband f Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Removal from State Highland Cemetery 9/20/04 Street, MD 4 ☐ Donation 5 ☐ Other (Specify) 17314 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Harkins F.H.Inc.,600 Main St.,Delta,PA ant 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final plasmacytema Physician disease or condition resulting in death) cancer: 4 yes /Medical Due to (or as a consequend **Examiner** monic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the burial-tran that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an autopsy performe 2 No certificate Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To his Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after d filled in by 4 Homicide 10 Hospital 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai completely (Check only one) Medi and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DrGillian Adams, 104 Plumtree Rd., Suite 102, Bel Air, MD 21014 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 1:35 PM Dorothy Crosson Jones September 18, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Edenton Assisted Living Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖸 F 85 June 25, 1919 Washington, D.C 578-16-7220 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County th and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Exturillier must be notified at 1 ☐ Yes 2 ☑ No Directo Frederick Maryland | Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21703 United States 5849 Genesis Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baitimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other traumatic event size. Be Mary Phillips Ernest Wilmer Crosson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6251 Rainier Drive, Frederick, Maryland 21703 Timothy L. Jones / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 23, Oak Hill Cemetery 2004 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 Home / 21. Signature of Funeral Service Licensee MO1356 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** End Stage Dementia Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Alzheimer's Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🛣 No ίç 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Congestive Heart Failure Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate 2 🔀 No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 SOther (Specify) Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No ို 1 Yes his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide 24 hours a e Funerail 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 20, 2004 D22101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 Taney Avenue, #204, Frederick, Maryland 21701 Lloyd E. Halvorson, M.D., 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State Registrar SEP 2 2 2004

	لي	State Registrar  1. Decedent's Name (First, Middle, Last			rtment of H F per me tificate of L		2. Date of Dea	th -	-	-3. Time of Death
Physici	an	Robert Kemp					August	25	Year 2004	1:33 P
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death			ty of Death	1 - 1 - 1 - 1
Examili	CI.	Washington County	Hospital		Hagerst	OWn		Wa	shing	iton
Funeral		Social Security Number 6. Se	x 7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Forei
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cate be executed physician and the burial-transit	dical Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ence of):						
The law requires that the death certificate be execut ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1	death 3[	□Ectopic pregnancy □ Other (specify)				ate of deliv-	ery Day Year
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the Ho hin 24 the Fu	Medic	one) A	and manner stated.	on and/or I	29c. License			29d. Date sign		
Neit Con	2	29b. Signature and title of certifier	Shall M.D.			c.M.E.		August		
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			1 - State Registrar		Cer	tificate of L	Death		g. No.	14	<u> 29950                                   </u>
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		4	For State Registrer	State of N	Marylan		artment o			nd M	F	leg. No.		29951
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	filed within 72 hours after death with the Maryland Hydione. ther than "natural", or Items 23a or 28a-f show ant, the Medical Evarti or mint be collided at	Funeral Director	10e. Street and Number 11013 Gates Dr				10f. Zip Co					-	en of What Co	ountry?
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Maryland 21215-0036	12 sho h and l 7 is me traume		19a. Informant's Name/Relations		·r						i Route Numbe			Zip Code) 20745
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Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If items 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Every incrinist be rediffied at ange.		21. Signature of Funeral Service	License		6	2. Name and A 160 Oxa	აი H იი	약 5년 <sup>(i)</sup> [i 11	P. K Road	alas Fu Oxon H	nera Mill.	ıl Home Marvl	PA and 20745
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Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√2√No	Hospital:	patient 2	ER/Outpatie	nt 3□ DOA	Other:			n (Check only o me Ya ∏resid		S □Other (Spe	ecify)
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	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in E	Med	29b. Signature and title of certifications of the certification of the c	er MO			29c. L	icense r	number 33	46	CLIN	29d. Dat	e signed (Mon	nth, Day. Year)
	ıD		30 Name and oddress of person	n who completed cause	of death (Ite	m 23a) (Type	Print)	D. #	+20	(	CLINI	TON	aus	20735
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	Regist	rar	SEP 22	2004	10 10	17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MANYA I. 9.10 pm **Physician** KATZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RANDALLSTOWN BALTIMORE NORTHWEST HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth

Month Day, Year)

JAN. 3, 1914 Birthplace (State or Foreign Country)
 TALE 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☑ F 90 UKRAINE 220-35-9245 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10h. County or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No BALTIMORE BALTIMORE Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21209 USA 2741 QUARRY HEIGHTS WAY Items 23e Be Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married WHITE ٥ 1 ☐ Yes 2 X No Specify. Baltimore, Maryland 21215-0036 Specify 3 X Widowed 4 □ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER of Health and Mental Hygie litem 27 le marked other I r other treumetic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fit timent of Health and Mental Heart: If item 27 le marked ott jury or other treumetic even **BERKOVSKAYA** KATZ RAOUEL ISAAC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2741 OUARRY HEIGHTS WAY - BALTIMORE, MD 21209 ALLA DELLER / GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. BALTIMORE HEBREW CEM 9/20/2004 REISTERSTOWN, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Menmonie **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ it we 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 Avo 1 ☐ Yes 2 ☐ No Division of Vital o the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Depatient 2 ER/Outpatient 3 DOA ٩ 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide The certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) 2004

29b. Signature and title of certifier

Comolivany



and manner stated

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

Northhet Hospital

29d. Date signed (Month, Day, Year)

29c. License number

054288

			For	State of Marylan				lental Hy	giene	0.01	معمور بدر براد	£Th.
			For State Registrar		Certifica	te of D	Death		Reg. No.	UUL	2995	3
	Physicia	an	Decedent's Name (First, Middle, Las	0				2. Date of De	Day	Year	3. Time of De	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. City	, Town, or I	Location of Death	agai.	4c.	County of De	1	
			St. Agnes	Hospital	$\mathbb{R}$	alti	MOSE If Under 24 Hrs.	la Bara at Bi		N	A	
	Funeral Director		5. Social Security Number 6. Se	M 2X F	Yrs. Months	or 1 Year Days	Hours Min.	8. Date of Bir (Month, Da	y Year)	35	rthplace (State or Fe	oreign OL
			Usual Residence of Decedent	110c Cit	y, Town or Location				~ / / / /		10d. Inside City L	
	ith the Marylan or 28e-f show to notified at	or	10a. State 10b. County	A F	30 1+im	nro					1 XYes 2	
	ours after death with the Maryla ral', or Itams 23a or 28e-f shov Examilier cust be notified at	Funeral Director	10e. Street and Number		10f. Z	ip Code	- 0		10g. Citiz	zen of What C	Country?	
	s 23a	ral	37 S. Pula	12. Was Decedent Ever in U.	S 13 Was Dec	2/2	223	acify Vas or No	)- 1	U.S.	nerican Indian,	
(0	after deal	Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 □ Yes 2 No If Yes, Give	If Yes, sp	5/	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		Black, Wh		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uthar than "netural", or Itams 23a or 28e-f show int, the Madical Examinar coust be notified at	d by	3 □ Widowed 4 ☑ Divorced	Year or Dates:	16a. Decedent's Us					Specify: Ind of Busines	Sack	
5	in 72 in "net	Completed	15. Decedent's Ed (Specify only highest gra Elementapy/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give kind of w	rork done di use retired)	uring most of work	ing	4 /		11/ 14	1
212	filed with Hygiene other the	Com	9	0	uner		oyed	- (First Middle	Ne	ver	Worke	4
and	ntai H ad oth	Be	17. Father's Name (First, Middle, Last)	SATUAGE		′	18. Mother's Nam	(First, Middle	) n r	anname)		
Maryland	2 should be and Mental is markad c sumatic eve	To	19a. Informant's Name/Relationship	Type, Print) (Sister)	19b. Mailing Addres	ss (Street a	nd Number or Ruj	al Route Numb	er, City be	Town, State,	Zip Code)	
	1 and 2 Health a sam 27 is		Mrs. Ella t	Kosenboro	37 S. Place of Disposition (N	Pul	aski	St. E	20c. Lo	cation - City o	1. 212= ir Town, State	23
nore	ages 1 nt of H t: If ita y or ot		20a. Method of Disposition  1	Removal from State	emetery, crematory or	other place		7/2004	10	n < dr	wine N	11
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is markad othar than "netur any injury or other traumatic evant, Ita Madical once.		21. Signature of Funeral Service Voen			and Address	s of Eacility	T	and I	11-000	conc <sub>1</sub> i	
ä	Depa Impo any in		Joseph	d' Bus	1 Jose f	WIN	K Ation	ve. P	salt	e Ma	21216 Approximate	<u> </u>
			23a. Part J. Enter the disease, or company, or heart failure. List only	one cause on each line.	n. Do not enter the mo	ndi	el enfo	or respiratory a	111051,		Interval Between	en ith
>	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	1		^			sary.	
45	Examiner	_	Sequentially list conditions,	b. Corone	en ath	eros	clero	als			years	4
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a conseq	dericar or).							
oʻ	be executed ician and burial-transit		that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
68760,	e X e	dlcal		d								
Box 6	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					2	23d. Date of d		
	Attending Physician: The law requires that the death certifica cleath. cleath. ector. After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	by Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown						Month	Day Yea	r
P.0	es that the death igned by the atte be detached for	, Phy	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause give	n in Part I.	23e. Did	tobacco u	se contribute	to the cause of deat	h2/
Records,	quires quires an signer and per uld be							1 🗆	Yes 2	□No 3□F	Probably 4 Junk	nown
600	law requit as been s	Completed						24a. Was	psy	24b. Were a	autopsy findings ava	lable e of
al R	n: The icate h						OC Plans of Passet	1. Yes	ormed? 2 ☐ No	1 Z Ye	s 2 No	
Vital	yeician: The lav iis certificate has director, page 2	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑Inpatient 2 □	ER/Outpatient 3	Othe	26. Place of Deat ar: 4 ☐ Nursing Ho			S □Other (Sp	ecify)	
n of	ding Phye h. After this funeral di	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury	y occurred		
Division	Attendi death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not b		ome, farm, street, facto		/es 2□No				Rural Route Number	
2	at or A s after of Dire	Certi	4 Homicide	building, etc. (Specif	(y)			City or To	wn, State,	}		
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the tim on, in my op	e, date and place, pinion, death occur	and due to the red at the time	cause(s) , date and	and manner a place, and du	as stated. ue to the cause(s)	
_	ro the within 2	Med	29b. Signature and title of certifier			9c. License			29d. Date	e signed (Moi	nth, Day, Year)	
	A		Filleam	J. Thicken	1		04964		1	21/64	0	
	3		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)	SNES	HOSPITH	L PACE	TIMOR	E. Mr	21229	
	st.		31. Date filod (Month, Day, Year)	32. Registrar's Signa		who						
	Regist	rar	SEP 2 2 2004		/- /-							

			State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar Certificate of Death Reg. No. 1 1	10011
			1. Decedent's Name (First, Middle, Last)  2. Date of Death	3. Time of Death
	Physici			9:44PM
	/Medio		the Charles of Double of Double	
			University of Maryland Medical System Baltymore, MID NA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthpla	ce (State or Foreign
	Director		213-52-9918 1211 25 418 1810 26,1948 1810	ryland
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10c	d. Inside City Limits
	Maryl f sho led a	ō	Mardand N/A Bultimore	1 Yes 2 □ No
	288 288	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country	y?
	3e or			
	deati	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
9	or ite	正	1 □ Never Married 2 Married 1 □ Yes 2 No   1 □ Yes 2 No   Specify: Specify: Specify:	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Madical Examalme town the collined at	d by	3 Widowed 4 Divorced Year or Dates:	CK
5	"net	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Indu (Give kind of work done during most of working (file. DO NOT use retired)	stry
12	withir ene. then	E G	Elementary/Secondary (0-12) College (1-4or 5+)	ruice
	filed with Hygiene other the ent, the			10100
<u>la</u> n	ould be Mental arked o	To Be		
Maryland	2 should be filed and Mental Hygi is marked other aumatic event, I	_	19a. Informant's Name/Relationship (Type, Print) (doughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C	code)
_	1 and 2 Health a em 27 is		Mrs. Angela K. Fleming 309 W. 27th St. Balto, Md. 212	[[
ore	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23e or 28e-f show or other traumatic event, the Marital Example in that the mailtied at		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Tow	n, State
Ĕ	Ly and Pa		· 4 Donation 5 Other (Specify) NT. Zion 7/21/2004 Lansdow	ne, IVId.
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr once.		21. Signatore of Funeral Service Ucensee 22. Name and Address of Facility  Joseph L. Russ Fineral Home	/
11.1	ĕ.□ ⊑ ē ā		Jeel Ch X MUN 2222 W North Ave. Balto Md. 217	16
			shock or heart fail b. List only one cause on each line.	Approximate nterval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	
	/Medical Examiner		Due to (or as a consequence of):	
		-	Sequentially list conditions,  if any leading to immediate  Due to (or as a consequence of):	
	nted Insit	Examiner	bif any, leading to immediate Due to (or as a consequence of):     cause. Enter Underlying     Cause (Disease or injury	
Ć,	execunand and ial-tra	Exal	that initiated events c. Due to (or as a consequence of):	
8760	sate be executed physician and the burial-transit	dicai	d	
9	death certificate be executed e attending physician and of for use as the burial-transil	ledi		
XO	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Date of delivery   Month   D	
O.B	he att	sici	in the past 12 months?    Section Description   Section Descriptio	ay Year
P.0	that the de led by the a detached f	Physician/Me	9 Dunknown  Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the	cause of death?
ls,	200			
O.O.	w require been si should b	eted	1 Yes 2 No 3 Probat	
Records,	e law has b	Completed by	24a. Was an autopsy prior to competition death?	y findings available detion of cause of
_	T 9 8			□ No
Vital	iding Physicien: The Sterifica straight of the	Be	examiner?	
of	Physic this stal di	5. To	Tampatein 2 Ervoupateit 3 Do 4 Nuising noine 5 Hesidence 6 Other (Specify)	
on	th: : Afte	tio	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
Division	l or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Form)	Route Number,
Ö	i Pitto	Certification:	building, etc. (Specify)  City or Town, State)	
	To the Hospital within 24 hours a To the Funeral is completely filled			ed.
	the Hin 24 the Fi	Medical	one) and manner stated.	
	To To Econ	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Die	y, Year)
,	t.		Ween (1854 ) 14451 Sept. 18,20	004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 301
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	1901
	Sta Registi		and his series by the series of the series o	

TINA LEGG

	1	For Stata Registrar		,		tificate of	Health and <i>Death</i>		Reg. No		20000
	_	Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Da	ay Year	3. Time of Death
iar ica		Tina L	ou	Legg				Septem		22, 200	1
ne		la. Facility Name (If not institution,				4b. City, Town,	or Location of De	eath		c. County of Dea	
		Stella Maris Ho 5. Social Security Number		ter 7. Age (In yrs. Ia	st hirthday)	Timonia If Under 1 Year		Irs. 8. Date of B	irth	altimor	Cirthplace (State or Fore Country)
		219–34–1769 Usual Residence of Decedent	1□M 2 <b>Ŭ</b> F	69	Yrs.	Months Days	Hours M	in. (Month, D July 1	ay, Year	35 We	est Virgini
		10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Lim 1 ☐ Yes 24☐1
	<u> </u>	Maryland Balti	more	Esse	X	10f. Zip Code			100 0	itizen of What C	
5		10e. Street and Number	<b>3</b>	t "B"		21221			10g. C		Southly !
בחובום	-	325 S. Marlyn A 11. Marital Status	12. Was Deced	dent Ever in U.S	. 13.		Hispanic Origin?	(Specify Yes or Nerto Rican, etc.)	0-	S. A.	
	2	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☒ Divorced	Armed Ford  1  Yes 2  If Yes, Give Year or Da	2 ( <b>X</b> No		1 Tes, specify Cui		eno Alcan, etc.)		Black, Wh Specify:	hite
ı	3	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual Occu kind of work done	ipation	workina	16b. l	Kind of Busines	
	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retir	ed)		_		
	3	12 17. Father's Name (First, Middle, L	ast)		Barte	ender	18. Mother's	Name (First, Middle	_	ar n Sumame)	
	ž	Hugh Elias	Spenc	ے				Ferrell		- ,	
	•	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Stree		Rurai Route Numi	ber, City	or Town, State,	Zip Code)
		Sandra Marie Ed	wards (Da			Cross 1	Lane Ab	ingdon, 1	Mary	land 21	009
		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from S		nce of Dispo metery, crer	sition (Name of matory or other pla	ace)	Date /25	20c. L	ocation - City o	or Town, State
		*4 □ Donation 5 □ Other (Sp	ecity)			Crematory		684		timore,	Maryland
		21. Signature of Funeral Service L	icensee		$B_{r}^{22}$	Name and Addr UZOZINS	ress of Facility Ki Funer	al Home	PA		
	+	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	used the death.	Do not ent	er the mode of dy	lastern ring, such as card	Avenue diac or respiratory	ESSE. arrest,	x, Mary	land 21221 Approximate
		Immediate Cause (Final									Interval Between Onset and Death
		disease or condition resulting in death)	a. UROSE. Due to (c	PSTS or as a conseque	ence of):						
		Sequentially list conditions,				R DISEASI	8				
1		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseque	ence of):						
Ž		that initiated events resulting in death) Last	c	or as a conseque	ence of):						
			d								
į	-										
3		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregnan		Ectopic pregnan	су			23d. Date of de Month	elivery Day Year
	2	in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	4□ Pregna 9□ Unkno	ant at time of dea wn	ath 5	Other (specify)				WORL	buy roan
			ns contributing to de	ath but not resul	ting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco	use contribute	lo the cause of death?
PHYSICIANINA		Part II. Other significant conditio						1	Yes 2	2 □ No 3 □ F	robably 4XUnknow
		Part II. Other significant conditio								24b. Were a	autopsy findings availal
		Part II. Other significant conditio					··· <u>-</u> · · · · · · · · · · · · · · · · · · ·	24a. Wa			
ompleted by Physician/Medical	1	Part II. Other significant conditio						e auto	opsy formed?	death?	as 2 No
e Completed		25. Was case referred to medical					26. Place of I	_ auto	opsy formed? 2 X N	death?	es 2 No
	To be combiered					IL 3L DUA	ther: 4 Nursin	autoperior 1 Yes  Death (Check only)  g Home 5 Res	opsy formed? 2 No one) sidence	o death? 1 □ Ye 6 ▼Other (Sp	
10 Be Completed		25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date o		R/Outpatier 28b. Time o Injury	f 28c. Inju	ther: 4 Nursin ury at ork?	auto per 1 Yes	opsy formed? 2 No one) sidence	o death? 1 □ Ye 6 ▼Other (Sp	***
		25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig 2 Accident investig 3 Suicide 6 Could n	28a. Date of (Month ation of be	f Injury n, Day Year)	28b. Time o Injury	f 28c. Inju	ther: 4 Nursin ury at ork? Yes 2 No	autropen 1   Death (Check only) g Home 5   Res 28d. Describe	opsy formed? 2 No one) sidence	death? 1  Ye  6  Other (Sp	ecify) HOSPICI
	to be completed	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner Oeath  1 Natural 5 Pending 2 Accident investig	28a. Date of (Month) ation of be 28e. Place	f Injury n, Day Year)	28b. Time or Injury	f 28c. Inju	ther: 4 Nursin ury at ork? Yes 2 No	autropen 1   Death (Check only) g Home 5   Res 28d. Describe	opsy formed? 2 No one) sidence how inju	death? 1 Ye  6 Other (Spury occurred	***
	cermication; to be completed	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pendin, investig 3  Suicide 6 Could n determi  29a. Certifier 1 Certifyin.	28a. Date of (Month ation of be ned 28e. Place building Physician: To the examiner: On the ba	of Injury on, Day Year) of Injury - At horing, etc. (Specify) best of my knowsis of examinati	28b. Time o Injury me, farm, str	f 28c. Inju M 1[ reet, factory, office	ther: 4 Nursin	autr per 1	opsy formed? 2 X No one) sidence how inju	death? 1 Ye  6 Tother (Sp ury occurred  and Number or F e)	HOSPICE Rural Route Number, as stated.
	Certification; 10 be completed	25. Was case referred to medical examiner?  1	ation ot be ned 28e. Place building	of Injury on, Day Year) of Injury - At horing, etc. (Specify) best of my knowsis of examinati	28b. Time o Injury me, farm, str	f 28c. Inju M 1[ reet, factory, office h occurred at the vestigation, in my	ther: 4 Nursin	autr per 1	one) sidence how inju (Street a pwn, State) e cause(s, date and da	death? 1 Ye  6 Tother (Sp ury occurred  and Number or F e)	HOSPICE  Rural Route Number,  as stated.  ue to the cause(s)
A	To Be Completed	25. Was case referred to medical examiner?  1	28a. Date of (Month ation of be ned 28e. Place building Physician: To the examiner: On the ba	of Injury on, Day Year) of Injury - At horing, etc. (Specify) best of my knowsis of examinati	28b. Time o Injury me, farm, str	f 28c. Inju M 1[ reet, factory, office h occurred at the vestigation, in my	time, date and ploppinion, death o	autr per 1	one) sidence how inju (Street a pwn, State) e cause(s, date and da	death? 1  Ye  6  Other (Spury occurred  and Number or Re)  s) and manner and place, and du	HOSPICE  Rural Route Number,  as stated.  ue to the cause(s)

State Registrar DHMH 17 Rev 1/2001

			Please	State of Ma						•		_	ie.		
			1 - For State Registrar		ai yiai i	•			Death		Reg.	200	Ĺ	299	56
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Margaret Amelia I							Mon	of Death th RMDe/	20 2	7ear 004	3. Time of D	
•	Examin		4a. Fecility Name (If not institution, give		110	anles	4b. City	_	Location of Deat	h		4c. County o	Death		
	Funeral Director		5. Social Security Number 6. S	NEW MECHO BX 7. A9 □ M 21XIF 83	e (In yrs.	last birthday) _ Yrs.	If Unde Months	r 1 Year	If Under 24 Hrs Hours Min.	8. Date (Mor Dec.	of Birth oth, Day, Yo 22, 19	ear) 920	9. Birthpla Count Mary	ace (State or I y) Land	Foreign
7	- A		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Loc	ation						10	d. Inside City	Limits
Mond	Maryin	tor	Maryland Harford	l		Jopp	a							1 🗌 Yes 2	!⊠No
de dei	oearri witi tre Maryanu ms 23a or 28a-f show f must be notified at	Funeral Directo	10e. Street and Number 110 Duryea Drive				10f. Z	p Code 210	85		10g	Citizen of Wh		ry?	
4	ms 23a	era	11. Marital Status	12. Was Decedent	Ever in U	S. 13. W	/as Dec		ispanic Origin? (S an, Mexican, Puer	pecify Yes	or No-	14. Race	- America		
5-0036	o within 72 flouts after bearn with the malyran jiene. Jiene. Then "natural", or Neme 23a or 28a-1 show The Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No			ecity Cuba 2 <b>∑</b> No	Specify:	to rican, e	ic.)	Specify:	White, e		
ביים ביים	"natu	letec	15. Decedent's Ed (Specify only highest gra			16a. Decede (Give k life. O	and of w		during most of wo	rking	16	o. Kind of Bus	iness/Ind	ustry	
717	illed within 72 I Hygiene. Other than "nat rent, tre Medici	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		Teac	cher			Cc	smetol	ogy i	School	
	# E & S	Be	17. Father's Name <i>(First, Middle, Last)</i> Martin A. Wedin						18. Mother's Na Anna Kr		Middle, Mai	den Sumame	)		
Maryland	snould ind Men ind marke umatic	2	19a. Informant's Name/Relationship	Туре, Print)		19b. Mailing	g Addres	ss (Street	and Number or R		Number, C	ity or Town, S	tate, Zip	Code)	
	and 2 ; sealth ar n 27 is ner trau		Lynda Hodges (Dau	ighter)					ive Jopp					,	
S :	of H		20a. Method of Disposition 1 1 Burial 2 □ Cremation 3 □			lace of Dispos emetery, crem				Date		c. Location - C			
Baltimore,	permit. Page Department. Important: If eny injury or once.		* 4 □Donation 5 □Other (Specifical Signature) of Funeral Service Licer	<u> </u>	Sac	-			esus 9/22 ss of Facility Ki Funer			altimor	e, N	aryıan	<u>u</u>
ñ	Ped of the second		John W. Burs	rouske			407	Old	<u> Eastern</u>	Avenu	e Ess	ex, Ma	ryla	nd 212	21
	n		23a Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each li	the deat ne.	h. Do not ente	r the mo	oo of dyin	g, such as cardia	c or respira	itory arrest	•		Approximate Interval Betwee Onset and De	
	hysician /Medical		disease or condition resulting in death)	a. Arrth	aconseq										
E	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. CAD  Due to (or as	0.000000	uance of									
	ured ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence on.									
<b>6</b> 0,	e be executed sician and e burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):									
	icate b physic s the b	dicai		d											
Вох	leath certificate attending physi I for use as the i	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic	pregnancy	,			23d. Date		-	
о О	ne deat the att	ysick	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			Other (					Mont	n i	Day Ye	ar
s, P.O	res that the de signed by the a l be detached l	by Ph	Part II. Dther significant conditions of	ontributing to death b	ut not res	ulting in the un	derlying	cause giv	en in Part I.	236		co use contrib		. ,	
ord	w require been sig should b										- :	2 □ No 3			
Division of Vital Records,	: The law requires that the death centificate are the attending phy: page 2 should be detached for use as the	Completed									. Was an autopsy performer Yes 2 C	d? pr	or to com ath?	sy findings av ipletion of cau 2□ No	
<u> </u>	s certifi irector	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ent 2	ER/Outpatient	3 🗆 [	Oth Oth	26. Place of De			e 6 □Other	(Snecify	)	
n of	ng Phy ter this neral c	on; To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry	28b. Time of Injury		28c. Injur Wor				injury occurre			
Sio	tendin death. tor: Ai the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	e Jac Blace of Inc	iuny - At h	ome form etre	M .		Yes 2 □No	28f Loc	ation (Stree	at and Number	or Bural	Route Numbe	97
	al or Al after of Direct d in by	Certification:	4 Homicide determined	building, et	c. (Specia	y)	et, lact	ary, oince			or Town, S		Or riula)	riodio riambe	31,
	To the Hospital or Attending Physician: The law within 24 burus atter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)	nysician: To the best miner: On the basis o and manner st	f examina	wledge, death tion and/or inv	occurre	d at the tir	ne, date and plac pinion, death occ	e, and due urred at the	to the caus time, date	se(s) and man and place, ar	ner as sta nd due to	ited. the cause(s)	
	To the complete	Me	29b. Signature and title of certifier	-	11.1.1	)	2		e number			Date signed			n,
7	0		> samuel			00-107	2-1-12	1776	705		76	ptemb	20	1201/20	~~~
	Y		30. Name and address of person who RACHELLE GAJADHA	IR ,5505	HOPK	INS BA	YVIE	W CI	RILE, B	ALTIN	NORE	MOZ	1224		
, de	Sta Regist		31. Date filed (Month Sep Year) 2	2004 32. R. distr	ar's Signa	ature /	234	2							

DHMH 17 Rev 1/2001

ORIGINAL

1 - For State Registrar 1. Decedent's

**Physician** 

/Medical

Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Markeul Example Triast by Incilling at ODEs.

**Physician** 

Physician/Medical Examiner

Be Completed by

Medical Certification; To

29a. Certifier (Check only one)

29b. Signature and title of certifier

Dr Taric Mahmood
31. Date filed (Month Day Year) 2 2004

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Plea	ase Type or	Print in Black	Indelible	Ink. Ens	ure Al	I Copies	Are	Legible.	
For State Registrar	State o	f Maryland / De	•	of Health of Death			giene Reg. No	001	29957
Decedent's Name (First, Middle CATHERINE FLOR						2. Date of Dea Month SEPTEM	Da	y Year 17,200	
4a. Facility Name (If not institution	n, give street and nui	mber)	· ·	own, or Location	of Death	<u> </u>	4c.	County of Dea	ath
STELLA MARIS F	6. Sex	7. Age (In yrs. last birth)	day) If Under 1		r 24 Hrs.	8. Date of Birti (Month, Day	h	BALTIMO 9. Bj	rthplace (State or Foreign Country)
220-05-0799 Usual Residence of Decedent	1□M 2□F	83 Yr	s. Months	Days Hours	Min.	1-8-19			ARYLAND
10a. State 10b. County	,	10c. City, Town o	or Location						10d. Inside City Limits
MD. HARF	ORD	HYD		N. 4.			10- 04		1 □ Yes 2,5No
10e. Street and Number 13035 HARFORD	ROAD		10f. Zip 0	1082			10g. Cit	izen of What C U.S	
11. Marital Status 1 ☐ Never Married 2 ☐ Mar	rned 1 ☐ Yes	rces? 2.∏No	13. Was Decede If Yes, specif	int of Hispanic Or y Cuban, Mexica	an, Puerto I	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify: T.7	ite, etc.
3 Widowed 4 □ Divorce	d Year or D	ates:	ecedent's Usual	Occupation			16b. K	ind of Busines	HITE s/Industry
	College (	(6)	Give kind of work ife. DO NOT use ACCOUNTA	done during mo retired)	st of workii	ng			RK & SEAL
17. Father's Name (First, Middle, Last)  JOHN SCHLEE  18. Mother's Name (First, Middle, Maiden Sumame)  FLORA (SCHMIDT)									
19a. Informant's Name/Relation PATRICA GIBSO				Street and Numb			-		Zip Code)
20a. Method of Disposition 1 → Burial 2 □ Cremation 1 → 4 □ Donation 5 □ Other (3	3 □Removal from Specify)	State cemetery,	isposition (Name crematory or oth	er place)		1-2004		cation - City o	r Town, State E, MARYLAND
21. Signature of Funeral Service	Licensee	tos	22. Name and 1211 CH	Address of Facili	VE. R	CH/ROSE OSEDALE	DALI Mi	E FUNER 0. 2123	AL HOME 7
23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that of t only one cause on e	caused the death. Do no each line.			s cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Due to	Or as a consequence of		cer					
Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequence of)	:						
cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence of)	:						
	(d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	tcome of pregnancy birth 2 Fetal death nant at time of death own	3 ☐Ectopic pres					23d. Date of de Month	elivery Day Year
Part II. Other significant condit	ions contributing to d	eath but not resulting in t	he underlying car	use given in Part	I.		es 2		o the cause of death?
						24a. Whas a autop perfor 1 ☐ Yes	sy	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medice examiner?  1 Yes 2 No	Hospital	Inpatient 2 ER/Outp	atient 3□ DOA	Other		(Check only or ne 5 ☐ Resid		6 Other (Spe	aciful Has as a se
27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date		ne of 28	c. Injury at Work? 1 Yes 2	2	28d. Describe h		-	Hospice
3 Suicide 6 Could	not be 28e. Place	of Injury - At home, farming, etc. (Specify)				28f. Location (S City or Tow	treet an n, State	d Number or F	Bural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D43725

29d. Date signed (Month, Day, Year)

Timoniom MD 21093

9-20-2004

/Medical **Examiner** within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Registrar

P

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Taria Mahmood, 2300 Dulaney Valley Rd.

31. Date filed (Month, Pay Year) 2 2004

32. Projetrar's Signature.

		For Stata Registrar			Cei	rtificate	of Dea	ith		Reg. No	nni	2005
Physici	an	Decedent's Name (First, Middle,      AADX E TALITION							2. Date of De Month	Day	2004 Yes	3. Time of De
/Media	al	MARY E. LAWTO		er)		4b City To	wn. or Loca	tion of Death	Sept.		County of De	
Examir	er	Stella Maris	gree direct and marile	0.,		Timor					Balti	
Funeral Director		5. Social Security Number 216–16–8835	.Sex 7. 1 □ M 21€ F	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 \ Months D	Year If U	nder 24 Hrs. urs Min.	8. Date of Bi (Month, Di Nov. 7	th ay, Year) 19	9. E	Birthplace (State or Fo Country) OWA
-f show	tor	Usual Residence of Decedent           10a. State         10b. County           Md •         Harf	ord	10c. City,	Town or Lo	cation Bel Ai	r				**	10d. Inside City L 1 ☐ Yes 2
3a or 28a	I Direc	10e. Street and Number 1311 Scottsdal	e Drive			10f. Zip Co	21015	5		-	izen of What nited	
perimer is again that the another than the state of the s	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force	es? ∑No		Was Deceden If Yes, specify		c Origin? (Spe xican, Puerto l ecify:	ecify Yes or No Rican, etc.)	)-	14. Race - Ar Black, W Specify:	
e. Andical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4	or 5+)	(Give life.		Occupation done during retired)	most of worki	ng		ind of Busine	ss/Industry
her th	Cor	12 years 17. Father's Name (First, Middle, La	pet)		home	maker	18 A	Aother's Name	(First, Middle		n home	
Mental H	To Be	Joseph W. O Co	nnor		10h Mailir	a Address /S	E	llen Sc	•			Zin Code)
Ith and 27 Is r traur		Joseph Lawton/										. 21013
nt of Hea		20a. Method of Disposition 1	I □Removal from St	ate ce	metery, crei	sition (Name matory or othe Cemet	er place)	9/21/	)ate		cation - City	or Town, State
Departme Important any injury		1 d □ Donation 5 □ Other (Special Structure of Frincial Structure Liver of Frincial Structure Liver of Frincial Structure Liver of Frincial Structure Liver of Frincial Structure (Special Structure of Frincial Structure		Var		2. Name and A	Address of F	acility	FUNCEA			GIO WMG
/Medical dispression and brainial-transit as the burial-transit	sal Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b Due to (or	as a consequence as a c	ence of):							
attending physor use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown		h 2 ☐ Fetal It at time of de	death 3	Ectopic preg Other (speci					23d. Date of o	delivery Day Yea
the	by	Part II. Other significant condition	s contributing to dea	th but not resu	lting in the u	nderlying cau	se given in f	Part I.		tobacco u Yes 2		to the cause of dea
n signed by the atte	0								24a. Was auto perfe 1  Yes		prior t	autopsy findings ava o completion of caus ? es 2 \( \square\) No
ete hes been signed by the a page 2 should be detached	Completed					-	26 8	Place of Death	(Check only			11.0
entificate has been signed by the ector, page 2 should be detached	Be Completed	25. Was case relerred to medical examiner?	Hospital:				Other					
h. After this certificate has been signed by the i funeral director, page 2 should be detached	To Be	examiner? 1  Yes 2 No  27. Manner ol Death 1  Natural 5  Pending			ER/Outpatier 28b. Time of Injury	nt 3□ DOA f 28c. M	Other	2	me 5 Res 28d. Describe		6 SOther (S) y occurred	pecify) TCSP10
ing rippercent. The terr requires that the definition of the this certificate has been signed by the ineral director, page 2 should be detached	To Be	examiner? 1 Yes 2 No 27. Manner ol Death	28a. Date of (Month,	Injury	28b. Time of Injury	M 28c	Other: 4[ . Injury at Work? 1  Yes	2 □ No	28d. Describe	how injur	y occurred	Rural Route Number
within 2 to spread or weed at the state of t	Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  Certifying	28a. Date of (Month,	Injury Day Year)  I Injury - At hor, etc. (Specify, etc.)	28b. Time of Injury  me, farm, str	M 28c.  M eet, factory, o	Other: 4[ .injury at Work? 1 □ Yes  the time, da	2 No	28d. Describe 28l. Location ( City or To	Street an wn, State cause(s)	od Number or	Rural Route Number

		•	1 - For State of Maryla	•	artment of F rtificate of		-	giene Reg. No.	4 29959
	Physici	an	Decedent's Name (First, Middle, Last)  James	Wilbur	Lutz, Sr	•	2. Date of De	Day	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)			or Location of Death	Septemb	er 9, 20	004 11:58P <sup>M</sup>
	Examin	ėı	PONINSULA REGIONAL MEDICAL CO	20114	514	136414			COMICO
	Funeral Director		5. Social Security Number 6. Sex 1	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Nov . 2	h y, Year) 28,1928	Birthplace (State or Foreign Country)     Maryland
	and *		Usual Residence of Decedent	City, Town or Lo	ocation				10d. Inside City Limits
	Marylan f show	tor	Maryland Somerset			Station			1 ☐ Yes 3Æ No
	death with the Maryland ms 23e or 28a-f show	Director	10e. Street and Number		10f. Zip Code	1020		10g. Citizen of Wh	nat Country?
	er death wi		4798 Williams Drive	118 13		1838 Hispanic Origin? (Sp.	acifu Vac or No	United	States  American Indian,
336	after or ite	by Funerai	11. Marital Status  1 □ Never Married 2 ₩ Marned  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 ∰ Yes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cub.	an, Mexican, Puerto	Rican, etc.)		White
5-0	"neturel",	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Bus	iness/Industry
21215-0036	ig e g	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retire oftman	d)		Draft	ina
d 2	2 should be filed withir and Mental Hygiene. is marked othar than aumatic evant, Tio Ma	Be Co	12 Years 17. Father's Name (First, Middle, Last)		or chair	18. Mother's Name	e (First, Middle,		
ylar	should be and Mental s marked o umatic eva	To E	Frank W. Lutz				Mae Wor		
Maryland	ges 1 and 2 should be filed wit to of Health and Mental Hygiene If itam 27 is marked othar the or othar traumatic event, The		James W. Lutz, Jr. / Son			and Number or Run Road Dun			State, Zip Code) 21222
	s 1 and of Health itam 27 other tr		20a. Method of Disposition 20th	b. Place of Dispo	esition (Name of matory or other place	ce)	Date	20c. Location · C	City or Town, State
Baltimore,	Pages ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 15 ☐ Other (Specify)	•		9/14/2004		Jarrett	sville, MD
Balt	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service Licensee			ess of Facility Funeral Ave. Du			
	Pnysician /Medical Examiner	er	23a. Part1. Enter the disease, or omplications that caused the dishock, or heart/allure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	sequence of):  Sequence of):	d			rest,	Approximate Interval Batween Onset and Death
68760,	ficate be executed physician and is the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a const	sequence of):	rait	in fect	200		
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	etal death 3 [	Ectopic pregnancy Other (specify)	1		23d. Date Monti	,
rds, P	sign d be	by	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause giv	ren in Part I.			oute to the cause of death?
Vital Records,	The law ate has b page 2 sl	Completed	Corner Arting I	Inse	F22		24a. Was a autop: perfor 1 Tyes	sy prio mago/? dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 □ No
of Vita	Physiclan: Th this certificate ral director, pag	To Be		ER/Outpatien		4 LI Nuising Ho	me 5□Resid	ence 6 Other	
on o	fter fter	tlon:	27. Manner of Death Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred	1
Division	To the Hospitel or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - A building, etc. (Spe	t home, farm, stro	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	le Hospite 124 hours a Funara letely filler	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my leading to the property of the best of the property of the best of the property of the best of the property of the best of the property of the best of the property of the best of the best of the property of the best of th						
	To th within To th compl	Me	29b. Signature and title of certifier		29c. Licens	,		01.	(Month, Day, Year)
			MMV		D.	34768		117	104
	10+1		30. Name and address Aperson who completed cause of death (I	tem 23a) (Type,	Print)	34768 Salish	1///	no - 21	80/
	Sta	74 1	31. Date filed (Mothith, Oat Feld) 2 2 20042. Register's Sig	gnature &	Soulis	- misel	4,1	10010	
	Registr	ar							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 09 Year **Physician** 4:50 04 /Medical W. 40th St. 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) 700 Examiner Multicare Baltimore Co eswick N/A If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 2 😿 F 162-09-8877 98 August 14, Pennsylvania Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" --- any injury or other traumetic excessions. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1√XYes 2□No Maryland N/A Baltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 4305 St. Paul Street 21218 USA 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 N Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th N/A Seamstress Tailor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Michael Zolochik Anna Petro 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Eleanor Patterson/Granddaughter 4305 St. Paul Street Baltimore Maryland 21218 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sts. Peter and Paul 9/24/04 Springfield Pennsylvania 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc 5305 Harford Road Baltimore Maryland 21214 molena 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death \$Physician Immediate Cause (Final disease or condition resulting in death) /Medical damen to Examiner Examiner the bunel-trensit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ After this certificate has been signed funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 21 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 20 No 1 Tes wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel s efter deeth. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours To the Funeral ( Confining Physician. To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Local Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number of death (Item 23a) (Type, Print) 0. Name and addr State Registrar

			State of Maryland / Department of Health and Mental Hygiene  State Certificate of Death  State Registrar  Certificate of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death  Month  Day  Year  1. 12 12 12 12 12 12 12 12 12 12 12 12 12
*	/Medic	al	Betty Dawn Lyman  September 20 2004 10,00 M  4b. City, Town, or Location of Death  4c. County of Death
	Examin	er	North Arundel Hospital Glen Burnie Anne Arundel
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) Nonths Days Hours Min.  7. Age (In yrs. last birthday) Nonths Days Hours Min.  7. Age (In yrs. last birthday) Nonths Days Hours Min.  8. Date of Birth (Month, Day, Year) (Month, Day, Year) Nay 13, 1925  9. Birthplace (State or Foreign Country) Michigan
	aryland show	or	Usual Residence of Decedent  10a. State
	with the M s or 28a-f	Directo	106. Street and Number  613 Hammonds Lane  106. Zip Code  109. Citizen of What Country?  U•S•
036	be filed within 72 hours after death with the Maryland Hygiene. Id other then "naturel", or items 23e or 28e-f show event, the Madical Examination must be motified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 1 Yes, Sive Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 1 Yes, Specify: 1 Yes, Specify: 1 Yes 2 No Specify: 1 Yes 2 No Specify:
Maryland 21215-0036	filed within 72 ho Hygiene. other then "natur ent, the Wedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker  16b. Kind of Business/Industry  Own Home
land 2	d la b	To Be C	17. Father's Name (First, Middle, Last)  George Swanson  18. Mother's Name (First, Middle, Maiden Sumame)  Jean (not available)
	nd 2 saith ar 27 is 27 is r trau		19a. Informant's Name/Relationship (Type, Print)  Mark Lyman / Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  716 Sunnyfield Lane Baltimore, Maryland 21225
Baltimore,	e = 5		20a. Method of Disposition  1 DXBurial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Clen Haven Mem. Park 9/24/2004  Clen Burnie, Maryland
Balti	permit. Pa Departmen Importent: eny injury.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Gonce Funeral Service, P.A.  4001 Ritchie Highway Baltimore, Maryland 2122
760,	Can use as the burial-transit	Ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death  Onset and Death  Due to (or as a consequence of):  Chyonic Unstructive Pulmony Disease  Due to (or as a consequence of):  Due to (or as a consequence of):  Chyonic Unstructive Pulmony Disease  Due to (or as a consequence of):
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Physician/Med	IF FEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   Yea
	uiras that signed b Id be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Bunknown
Il Records,	sicien: The law requira certificate has been si lirector, page 2 should I	Completed	24a. Was an autopsy performed performed death?  1 Yes 2 No 1 Yes 2 No
Vital	Physicien: this certificatal director,	Be	25. Was case referred to medical examiner?  Hospital: Managing and FR/Outcoticet and
of	ng Phy fter this ineral d	atlon: To	1 Yes 2 No
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Afte completely filled in by the fune	Medical Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	he Hospit in 24 hour he Funere pletely fills	edical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
•	Tot Tot	M	29b. Signature and title of certifier C. Will M. M.D. 29c. License number September ZO, ZOC4
	2		29b. Signature and title of certifier  Lever C. Will M. D. D41365  September 20, 2004  30. Name and address of person who completed cause of death (Item 230) (Type, Print)  Lever E. Will M. D., 301 Hapital Drive, Glen Burnie, MD. 21061
• •	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 2 2004  32. Registrar's Signature

DHMH 17 Rev 1/2001

Lyman, Betty

ORIGINAL

			For State Registrar	State of Mary		artment of Hertificate of E			iene •g. Nô A A I	20000
			Decedent's Name (First, Middle, Last,	)				2. Date of Deat	th C U U	3. Time of Death
-2	Physicia /Medic		Rose M	larie Litz	zau			Septembe		
100	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of Death	
			Renaissance Garder  5. Social Security Number 6. Se		n yrs. last birthday)	If Under 1 Year	atonsvi	S O Date of Dieth	Baltimo	
R 1	Funeral Director			м 2 <b>1</b> 5 F 81		Months Days	Hours Mir		1923 Mar	npface (State or Foreign untry) yland
	pu *		Usuat Residence of Decedent  10a. State 10b. County	[10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Manyla f ehor	ō	Maryland Baltimo		,,	Catonsv	i11e			1 ☐ Yes 2 XNo
	the t	Director	10e. Street and Number	LC		10f. Zip Code	LTTC	1	0g. Citizen of What Co	untry?
	th with	ai Di	715 Maiden Choice	e Lane, CC6	11	2122	8		USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Itema 23a or 28a-f show importants if Item 27 is marked other than "natural", or Itema 23a on 28a-f show appropriaty by injury or other traumatic event, Ita Medical Examinat must be notified at approx.	by Funeral	11. Maritaf Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 X No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
5-0	72 ho netui	eted	15. Decedent's Edu (Specify only highest grad	ication e <i>completed)</i>	(Give	dent's Usuaf Occupa kind of work done d DO NOT use retired)	<i>uri</i> na most of wi	orking	16b. Kind of Business/l	ndustry
121	within ane. then	Completed	Efementary/Secondary (0-12)	College (1-4or 5+)		rical Supp			Telephone	Company
	Hygie Other enf.	Be Co	17. Father's Name (First, Middle, Last)					ame (First, Middle, M		T Z
<u>lan</u>	Aental Aental rked c	To B	Ferdinand Engel				Ethe1	Graves		
Maryland	2 should and Men Is marke sumatic		19a. Informant's Name/Relationship (T)						City or Town, State, Z	
	and sealth m 27		Walter C. Litzau/H		/15 N 20b. Place of Dispo		oice Lar	The second secon	Catonsvill  20c. Location - City or	e, MD 21228
Baltimore,	ment of H lant: If Ite		20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify)	Removal from State	cemetery, crei Metro Crei	matory or other place matory, I	nc. 9/2	1/04	Baltimore,	
Ball	permit. Departr Importa		21. Signature of Funeral Service Licens  Edward A., Greg	orchik	2	Rame and Addres remation 99 Freder	s of Facility Society ick Roa	of MD, I d Baltimo	nc. re, MD 2122	28
			23a. Part1. Enter the disease, of comp shock, or heart failure. List only of	lications that caused the ne cause on each fine.		-			*	Approximate Interval Between Onset and Death
7	Wysician		Immediate Cause (Final disease or condition resulting in death)	a	V/ /	alun	pn	eumon	Ca	
*	/Medical Examiner			Due to (or as a c	onseque#ce of):		/			
	h ==.	Jer	Sequentially fist conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of).					
	rcuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.						
50,	cate be executed physician and the burial-transit	i Ex	resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	physics the L	dlcai		d						
.O. Box 6	requires that the death certifi been signed by the attending I hould be detached for use as	Completed by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of defe Month	very Day Year
Δ.	that the hold by detail	y Ph	Part II. Other significent conditions co	ntributing to death but r	not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	- W 775	ed b	010	harf nge	ul di	nghagi	1	1 □ Y€	es a∕⊠No 3□Pro	obably 4 Unknown
Records,		plet		den	untea			24a. Was a autops	v prior to c	topsy findings available ompletion of cause of
- B	The ate h page	Com						perform 1 ☐ Yes 2	med? death? 2☑No 1☐Yes	2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospitaf:		Othe		eath (Check only on		
of	Physic this c	.T	1 ☐ Yes 2 1 No  27. Manner of Death	1 🗆 inpatient		nt 3 DOA	Nursing		ence 6 Other (Spec ow injury occurred	ify)
o	ding f th. After funer	tlon	1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Y	ear) Injury	Work	? ′es 2 □ No		,,	
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury building, etc. (	- At home, farm, sti Specify)	reet, factory, office	10000	28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 12 Certifying Phy (Check only one)	rsician: To the best of r iner: On the basis of ex and manner stated	amination and/or in	h occurred at the tim vestigation, in my op	e, date and place sinion, death occ	ce, and due to the ca curred at the time, di	ause(s) and manner as ate and place, and due	stated. to the cause(s)
•	To the within To the comple	Me	29b. Signature and title of certifier	m Mp		29c. License	number 00000	40 2	9d. Date signed (Month	O. gay, Year)
-	9		30. Name and address of person who o	ompleted cause of deat	h (Item 23a) (Type,	Print Cate	June	the N	10 2	1228
		ate	31. Date filed (Month, Day, Year)	n (2. Registrar's	Signature	1. 1				
	Regist	rar	SEP 2 2 2004	Alles vas	15 1					

1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year				For	State of Ma		d / Depa		Healt	h and Me			o I	000	c 0
Physician   Common				1 - State Registrar			Cei	rtificate o	t Dea				and the second	4471	73
46. County of County  Chart Hoppins Reynorth Modifical (Linker  Chart State County of County  Chart Handstow of County  15. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  25. Special Source Vulnitive  26. County of County  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Source Vulnitive  27. Special Special Source Vulnitive  27. Special Spec		Physici	an								Month	Day	0 0		
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Special power   Special powe		Examin	er			cal a	enter								
The content of the				5. Social Security Number 6. S	Sex 7. Age	e (In yrs. k	ast birthday)	If Under 1 Yea	ar If Un		Date of Birt (Month, Da			place (State or ntry)	r Foreign
Separation   Sep		pu 🛊				10c. City	. Town or Lo	ocation						0d. Inside Cit	ty Limits
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Separation   Sep	036	ours after dea ai', or items	by	1 Never Married 2 Married	Armed Forces? 1 XXes 2 □ N If Yes, Give			If Yes, specify Co	uban, Mex	dcan, Puerto Ri	fy Yes or No can, etc.)		Black, White,	etc.	
Separation   Sep	215-0	thin 72 ho e. sn "natur Medical	pieted	(Specify only highest gra	ade completed)	+)	(Give	kind of work do	ne during t	most of working				dustry	
Separation   Sep	7	ed wil	Соп	9 years			Bler	nder	10.11						
Physician Micelical Examiner  22a. Hyv. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease or conditions and the death of the disease or conditions and the disease or conditions are conditions.  22b. Was diseased from the disease or conditions of the disease or conditions are conditions. If any, leading to immostite that include disease or conditions of the disease or conditions of	/land	uld be fill Mental H irked oth	Be		,				100			Maiden Su	тате)		
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Physician // Add cause (Final disease or condition resulting in death)  Sequentially list conditions, a any legislation of the conditions		Ø□ = @ 0		222 Park Enter the disease or com	polications that caused	the death	Do not ent	110 Sol	lers	Point I	Road,	Dunda	IK,MD.		
Sometially list conditions, any regarding to immobilistic datase (Disease of Injury Park June 1998)  Sometially list conditions, any regarding to immobilistic datase (Disease of Injury Park June 1998)  If FEMALE:  23c. If yes, outcome of pregnancy  1   Use birth 2   Det to (or as a consequence of):  d. Due	,			Immediate Cause (Final disease or condition	a. aspira	hov	n prox							Interval Betw	veen
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10   10   10   10   10   10   10   10		pe sit	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	а сонъ <del>в</del> ци	erice of).								
10   10   10   10   10   10   10   10		al-tran	Exan	that initiated events	c. Due to (or as a	a consequ	ence of):						-		
FEMALE:   23b. Was decedant pregnant in the past 12 months?   1   res 2   No 9   Unknown   1   res 2   No 9   Unknown   1   res 2   No 9   Unknown   1   res 2   No 9   Unknown   1   res 2   No 9   Unknown   23d. Date of delivery   Month   Day   Year   1   res 2   No 9   Unknown   23d. Date of delivery   Month   Day   Year   1   res 2   No 9   Unknown   23d. Date of delivery   Month   Day   Year   1   res 2   No 9   Unknown   23d. Date of delivery   Month   Day   Year   1   res 2   No 10   I   res 2	760	ysiciar e buri	cail		_ d										
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26. Place of Death (Check only one)  27. Manner of Death   Yes   2 No   28a. Date of Injury   28b. Time of Inj	Ω.	that t	y Ph	Part II. Other significant conditions of	contributing to death bu	ıt not re <i>s</i> u	tting in the ur	nderlying cause (	given in Pa	art I.	23e. Did to	bacco use	contribute to th	e cause of de	eath?
26. Place of Death (Check only one)  27. Manner of Death   Yes   2 No   28a. Date of Injury   28b. Time of Inj	rds	quires in sign	q pe	chronic obstruct	ive pulme	nan	disce	rie, cor	rgest	ire	1 🗆 Y	es 2 <b>X</b>	lo 3 ☐ Prob	ably 4 □U	nknown
26. Place of Death (Check only one)  27. Manner of Death   Yes   2 No   28a. Date of Injury   28b. Time of Inj	eco	iaw reas bee	plet	neart failure	•								prior to cor		
26. Place of Death (Check only one)  27. Manner of Death   Yes   2 No   28a. Date of Injury   28b. Time of Inj	m m		Com								perfor	med?	death?		
27. Manner of Death   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Succident   Natural   Natural   Succident   Natural	/ita	ician: sertific ector,	Be	examiner?	Hospital:			HCC							
Signature and title of certifier  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier  29a. Certifier  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  31 Suicide  4 Homicide  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29c. License number  29d. Date signed (Month, Day, Year)  30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  31 Suicide  4 Homicide  29d. Date signed (Month, Day, Year)  32 Suicide  4 Homicide  29d. Date signed (Month, Day, Year)  32 Suicide  4 Homicide  29d. Date signed (Month, Day, Year)  32 Suicide  4 Homicide  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	of	<b>ਦ</b> ⊊ ह			1 Minpatie			t 3 DOA	urv at					")	
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State State Registrar  SEP 2 2 2004  32. Figistrar's Signature		w		TOINET SOFFFINA	completed cause of de	eath (Item	23a) (Type, BAVVI'E	Print) W Muli	cal Co	nter o					
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2002 **Physician** 18<sup>9</sup> Mattie Bernice McNeill 11:45 a.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Balto N/A 501 Dolphin Apt # 1215 Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Mogth, Day, Year) 28 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X** F 214-38-1630 76 N.C. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 Is marked other then "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 1√Yes 2 No Director MD NA BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 501 DOLPHIN ST. APT. #1215 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ò Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NURSE PROVIDENT HOSPITAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BLAND C. MCNEILL REBECCA BLUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARENCE MCNEILL, SR.-HUS. 501 DOLPHIN ST. #1215 BALTO., MD 21217 Department of Health ar Important: If itam 27 Is any injury or other traconce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State LOUDON PARK CEM. SEPT. 21,04 BALTO., MD \* 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Wabash Avenue Balto, Md 21215 4300 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart fail to. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final homa with **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4☐Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ed bluods 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 Yes 2 No 1 Yes 10 No or Attanding Physiclan: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after deatl To the Funaral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 405 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Entow 2 31. Date filed (Mont) SE 32. istrar's Signatur State 2004 Registrar

Sharon Mullineaux Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-5981 Unpend Item 25 1827 of Maryland & Department of Health and Mental Hygiene 1- For U Stata Registrar AKG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Sharon Ann Mullineaux September 16, 2004 4c. County of Death 1:49 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore ff Under 1 Year | Months | Days University Hospital N/A 8. Date of Birth (Month, Pay, Year) Jun. 14, 1954 If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ☐ M 2X F Hours 50 California Director 549-90-4155 Usual Residence of Decedent death with the Maryland 10c, City, Town or Location 10d. fnside City Limits 10b. County 10a State itams 23a or 28a-f ahow ner rant be notified at 1 ☑ Yes 2 ☐ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1421 Washington Blvd. 21230 Completed by Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. important: if Item 27 Is marked other than "natural", or Itams any injury or other traumatic event, the Medical Exercitive Fig. 0068. Black, White, etc. 1 □ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Window Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jack Arlen Heern ဥ Mary ELizabeth Haynie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Mullineaux Husband 1421 Washington Blvd., Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Bayview Crematory, Inc. 9-25-2004 Baltimore, MD 21. Signature of Funeral Service Excenses 22. Name and Address of Facility Ambrose Funeral Home, Inc. WW 2719 Hammonds Ferry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** Asthma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Causa (Discass or injur that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. detached the 9 dunknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ ficate has been sig r, page 2 should b 1 Tes 2 No 3 Probably 4 \$\textstyle Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 \sum No 24a. Was an autopsy performed? 1 X Yes certificate 2 No the Hospital or Attanding Physician: director, 25. Was case referred to medical 26. Pface of Death (Check only one) examiner' Hospital: 1 fnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1€XYes 2□ No 2 RVOutpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? Natural 2 Accident Injury 5 Pending 1 Yes 2 No investigation hours after death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's S

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

September 17, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 19. 2004 Robert September 6:15 P Messier Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Respite Home on South Haven Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral XM 2□ F Months 83 Director May 8, New York 072-14-1456 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Mudical Exams for most be notified at 1 Yes 2 No Annapolis Anne Arundel Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 2623 Rigging Drive Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:1940-45 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural, or Itan any injury or other trainment. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12th Printing Pressman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles W. Messier Anna Watts ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2623 Rigging Drive, Annapolis, MD 21401 Ida M. Messier/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 9-24-04 Edgewater, MD Kalas Crematory \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home White Elkle 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ernel /Medical Due to (or as a consequence of): Examiner uera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner bressi C be executed use as the burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2□ No 2 1 Tyes the Hospital or Attending Physician: hin 24 hours after death. the Funaral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Respite Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 5 Residence 6 Sother (Specify) Home 2 00 2 1 Yes 4 Nursing Home 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 | Homicide the certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and ti e of certifier 0 of person who completed cause of death (Item 23a) (Type, Print) ely Aut. Ste. 231 Annapolis, MD. ZI LODORIda 31. Date filed (Month, Day, Year) SEP 2 2 2004 2. Registrar's Signature State

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Registrar

Director  Direct			1 - For State Registrar	State of Mary				Mental Hygi	ene g. 190. () () (	. 20057
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aligate Holley MD Res-000 September 19	e Hosp 24 hou e Funel letely fil	dical	(Check only 2 Medical Examin	ier: On the basis of exam	knowledge, dea mination and/or i	ath occurred at the investigation, in my	time, date and place opinion, death occu	, and due to the caus rred at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
	To th within To th comp									
30. Name and address of person who complets cause of death (Item 23a) (Type, Print)	20				(Item 23a) (Type					
30. Name and address of person who complete cause of death (Item 23a) (Type, Print)  Abigail Holley MD; Johns Hopkins BMK, 4940 Eastern Ave, Baltimore  State  Registrar  SEP 2, 2, 2004  Denow  A  Local Complete Cause of death (Item 23a) (Type, Print)  Abigail Holley MD; Johns Hopkins BMK, 4940 Eastern Ave, Baltimore  State  SEP 2, 2, 2004  Denow	Sta	_	Abigail Holley M.C. 31. Data-Had (Month, Day, Year)	32. Registrar's S	PKINS .	BMC, 49	140 East	ern Ave, I	3altim	ore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer **Physician** August 20, 2004 1:00 PMM Ellen Melvin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Baltimore 5224 Wagon Shed Circle Owings Mills If Under 1 Year If Under 24 Hrs. 8. Date of Birth Man 1 Park 1930 Hours Min. Man 1 Park 1930 9. Birthplace (State or Foreign Mary Tand 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F 74 220-20-2156 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County ad other then "naturel", or itsms 23a or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 27 No Director Baltimore Owings Mills 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21117 USA 5224 Wagon Shed Circle Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: \*51–53 1 Yes 2X No Specify: Specify: black Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. disabled claims adjuster civil service Depertment of Health and Alenner Inportant: If item 27 is any injury or other any inju 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas S. Barland Anna Gaddis ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carol A. Melvin/daughter 5224 Wayon Shed Circle Owings Mills, ND 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 MOther (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 elicensee Wad 21. Signature of Euneral Secret ncul Approximate Interval Between Inset and Death 23a. Part | Enter the disease, or complications tha shock, or heart failure! List only one cause or or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition Physician /Medical resulting in death) Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year detached for in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 TYes 2 No 3 ☐ Probably 4 ☐Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 2₽No 1 ☐ Yes the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 | Yes / 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mann of Death 28b. Time of After 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Vithin 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nino 35398 ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 40, Owings Mills, MD 21117

State Registrar

FLAVIO BRUTER, 31. Date filed (Month, Day, Year)

32. Registrar's Signature 1 **ORIGINAL** 

CROSSROADS

			1 - For State Registrar	State of M	aryland / Depa	artment of F rtificate of		Re	g. No. 0 0 1	29969
	Physici	an	Decedent's Name (First, Middle, L.		ACT TO CEP			2. Date of Death Month	Day Ye	ar 3. Time of Death
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	Examin	ıer	4a. Facility Name (If not institution, g. 871 WILLYS DI		)	ARNOL	or Location of Death D	1		ARUNDEL
					ge (In yrs. last birthday)	If Under 1 Year		8. Date of Birth	9.	Birthplace (State or Foreign
н	Funeral Director			1□M XXF	77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 12/13/	1926 NC	Birthplace (State of Foreign Country) RTH INDUSTRY
			Usual Residence of Decedent							
	rylan show		10a. State 10b. County	E ARUNDEL	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※X No
	89-1 s	cto		E AKUNDEL	ARROL			1		
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code 210	1.2	10	og. Citizen of What USA	: Country?
	s 23e	ral	871 WILLYS DRI	VE 12. Was Decedent	Ever in U.S. 13			pecify Yes or No-		merican Indian,
	Item Inerr	Ľ,	11. Marital Status  1 □ Never Married 2 ₩ Married	Amed Forces	XIO		Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Vhite, etc.
936	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2XXXVo	Specify:		Specify:	WHITE
9	within 72 hours after death with the Maryland ene. than 'netural', or Items 23e or 28e-f show ha Medigal Examiner maal be notified at	Completed	15. Decedent's (Specify only highest g	Education	(Give	dent's Usual Occup	during most of wor	kina	6b. Kind of Busine	ess/Industry
21	thin ?	nple	Elementary/Secondary (0-12)	College (1-4or	5.\ life.	DO NOT use retire IRSING IN	d)		HOSPITA	AT.
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n a	be fill	Be	17. Father's Name (First, Middle, Las WALTER HANDSHU					ET CATHER		ZER
Maryland 21215-0036	2 should be and Mental Is marked of Bumatic eve	မ	19a. Informant's Name/Relationship		10h Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town Stat	e Zin Code)
Ma	d2sthandthand71sr		JACK MIESMER -					OLD, MAR		
	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23e or 28e-f show other treumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	HUSDAND	20b. Place of Dispo	osition (Name of			Oc. Location - City	
noi	Pages nent of h ant: If its ary or o		1 ☐ Burial 2 📉 🗓 remation 3 1 4 ☐ Donation 5 ☐ Other (Spec			matory`or other pla V CREMATO		/2004	BALTIMO	RE, MD
Baltimore,	그는 분구		21. Signature of Funeratory vice Lic		2	2. Name and Addre	ess of Facility	FINK FU	NERAL HO	
B	Departi Departi Impo		CREGO	ŘÝ FINK #	MO1148 42	26 CRAIN	HIGHWAY S	G., GLEN	BURNIE,	MD 21061
			23a. Part1. Enter the disease, or co shock, or heart allure. List onl Immediate Cause (Final	molications that cause	d the death. Do not en ine.	ter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Iner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Leaves (Disease or imper)	Due to (or as	s a consequence of):  Evtit s a consequence of):	· · ·				
68760,	ite be execut iysician and ne burial-trar	ledicai Examiner	resulting in death) Last	CDue to (or as	s a consequence of):					
.O. Box	it the death certificat by the attending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes XNo 9 □ Unknown		2 Fetal death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
rds, P	signed be de	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob		e to the cause of death?  Probably 4 Dunknown
Record		Completed						24a. Was an autopsy perform	prior	
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11		Oth	-	th (Check only one	)	
of \	Physicien: r this certific ral director,	ို	1 Yes 2 XX	Hospital: 1 Inpat		II 3 DOX		ome 5 XX esider 28d. Describe how		Specify)
	ng Aftei Ane	ion	27. Manner of Death 1 Anatural 5 ☐ Pending	28a. Date of Inj (Month, Di	ury 28b. Time o ay Year) Injury	Wo	rk?  Yes 2□No	20d. Describe no	w injury occurred	
Division	Atten	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Ir	jury - At home, farm, st tc. (Specify)		, 100 2 2 10	28f. Location (Str. City or Town,		Rural Route Number,
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	To the Hospitel or within 24 hours efter To the Funeral Dir. completely filled in I	edical	29a. Certifier XX Certifying F (Check only one) 2 Medical Exc	Physician: To the best eminer: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	h occurred at the tile vestigation, in my o	me, date and place ppinion, death occu	, and due to the ca rred at the time, da	use(s) and manner te and place, and o	r as stated. due to the cause(s)
. 1	To the within To the comple	Me	29b. Signature and title of certifier	2		29c. Licens	se number	29	d. Date signed (M	onth, Day, Year)
			1 Wage	ener	MI	Do	156 72	9 5	SEPTEMBER	20, 2004
7	10		30. Name and address of person wh	o completed cause of	death (Item 23a) (Type,		_	more,	MD 2	1201
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		- / 11	/		
	Registi		SEP 2 2 20	04	المراكب الأن ال	Wild a				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 11:28A 2004 September 20, Corinne A. Plitt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DePaul House 3300 Benson Avenue Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth April 1 23, 1923 9. Birthplace (State or Foreign Maryland 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2大 F 81 214-18-9168 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Madical Examinar must be notified at Halethorpe Baltimore Maryland 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 U. S. A. 3300 Unit 322 Benson Ave. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes. Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ★ No Specify: Yes. Give Specify. White þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Menfal Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, In Maulic once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Bank 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Genevieve Clark Clement Carson 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) 2401 Gillis Rd. Mt. Airy, MD. 21771 19a. Informant's Name/Relationship (Type, Print) Frederick Plitt, son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral 09-23-04 Baltimore, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signatur Funeral 3 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

Willow Levice Cardinor

Disease Approximate Interval Between Onset and Death cyclis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner law requires that the death certificate be execufed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Year Day 5 Other (specify) ed by the a Ö 9 Unknown signed by t d be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Color Carce 1 Yes 2 No 3 Probably 4 Unknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page certificate l 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🔀 No 2 After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; or Attending 1 Natural 5 Pending To the nusping after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 101 9/21/04 D24781 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Varlas KAller BALOTIMORE PINE HEIGHTS AVE 5300 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** September 15, 2004 1:10 AM M Dennis Walter Prior /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Edenton Retirement Community Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Ye Feb. 23, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number **Funeral** XXM 2□ F Months Days Hours Min Yrs. 62 215-42-2841 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthan "natural", or itams 23a or 28a-f show Its Medical Examiner ... ust by multiled at Frederick Frederick 1 ☐ Yes 2 No Maryland Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 5820 Genesis Lane, Apt. 518 21703 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 16b, Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Journalist Newspaper 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked othe any fully or other traumatic event, 20x8. 17. Father's Name (First, Middle, Last) Katharine Frohne Howard Anderson Prior 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 Prince Street, New York, New York, 10012 Carol McCutcheon, cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Sept. 15, 2004 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) 22, Name and Address of Facility Keeney and Basford PA\_Funeral Home 21. Signature of Funeral Service License M00255 106 East Church St., Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Squamous Cell Cancer of the Tonque 10 Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician are s the burial-t P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Cerebral Vascular Disease 1

Yes 2

No 3

Probably 4

Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease 24a. Was an autopsy performed? page 2 X No 1 🗌 Yes 2[XNo 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2X No P 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Certification: Living 1 Xatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Chack only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 22019 September 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lloyd E. Halvorson, M.D., 1475 Taney Ave., # 204, Frederick, MD 21702 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 2 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** September 10, 2004 9:30 AM M Bernard V. Plotczyk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. Nov 26, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 61 1942 Director 217-40-3014 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. Counts ty Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2216 S. Portugal Street 21231 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Motors unk machinest 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard Plotczyk Sr 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Dubiel/daughter 107 S. Conkling Street Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 🛛 Other (Specify) in state 21. Signature of Funeral Service Licensee

Ronald S Wade, Daractor State Anatom B and 655 W. B

3a. Pa 1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipk, or heart failure. List only one cause on each line. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZMS Physician /Medical Due to (or as a consequence with AIRNAY OBST W Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque te of) Examiner obst The law requires that the death certificate be executed use as the burial-transit 6 the attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ② No 24a. Was an autopsy 2 1 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 12 Other (Specify) Hospo 2 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours e To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 0002290 w/ac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AYE (0 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

SEP 2 2 2004

			State of Maryland / Dep	artment of Health and Martificate of Death	lental Hygier	21111. 2	9973
	0		Decedent's Name (First, Middle, Last)		2. Date of Death Sept. 19,	Day 2004 Year	3. Time of Death
	Physicia /Medic		Eugenia Isabella Philip	4b. City, Town, or Location of Death		4c. County of Death	3:00am м
	Examin	er	4a. Facility Name (If not institution, give street and number) Millennium of Ellicott City	Ellicott City		Howard	
	Funeral		5 Social Security Number 6. Sex 7, Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthpla Country	ce (State or Foreign y)
	Director		215-22-8862 1 M 2 F 77 Yrs.		DEC 19,	1926 Mary	yland
	and bw		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		100	d. Inside City Limits
	Mary If she	tor	Maryland Howard	Ellicott City			1 ☐ Yes 2 X No
	th the or 28a e noti	)irec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Countr	y?
	ath wi	rai	3000 N. Ridge Road	21043 Was Decedent of Hispanic Origin? (Sp.	ecity Yes or No-	USA 14. Race - America	n Indian,
40	72 hours after death with the Maryland Inatural; or Itams 23a or 28a-f show oldal Examinat must be notified at	Funeral Director	11. Marrial Status Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, et	
21215-0036	ours at	by	3XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 21X No Specify:		Specify: Who	
5-0	72 hc "natur	etec	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)		o. Kind of Business/Indu	ıstry
121	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ecretary		Electron	ics
פשר	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene item 27 is marked other than "natural", or itams 23a or 28a-1 show item 27 is marked other than "natural", or itams a mail to notified at other treumatic event, the Modical Exempter mail to notified at	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Sumame)	
ylar	should be ind Mentai marked o umatic eve	To	Owen R. Stagmer	Jesse  ling Address (Street and Number or Run	Emma Po		Code)
Baltimore, Maryland	12 sh h and 7 is m treum					le, MD 21	
re,	Healt tem 2 other		20h Place of Disc	position (Name of		c. Location - City or Tow	
ē	Pages ent of nt: if i		1 A Burial 2 □ Cremation 3 □ Removal from State   Crest La    '4 □ Donation 5 □ Other (Specify)   Memorial	ematory or other place) Wn Gardens 9/2	2/04 Ma	arriottsvil	le, MD
alti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tre		21. Signatura of Funeral Service Licensee	22. Name and Address of Facility MacNabb Funeral Hor	me, P.A.		
8	89 2 2 3		rdward A. Gregorchik  23a. Part1. Enter the disease, or complications that caused the death. Do not e	301 Frederick Road	Catonsvil		Approximate
			23a. Part1. Enter the disease, or complications that cause in a beautility shock, or heart failure. List only one cause on each line.	tic Cardio vasci	Mar Di	seare	Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):	(2 (3 2000)			
	Examiner		Sequentially list conditions b.				
	pi iii	iner	if any, leading to immediate ause. Enter Underlying  Due to (or as a consequence of):			Į	
_	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last  C				
8760,	sician buria	dicai E					
9	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the bural-transit	fedic					
Вох	leath certific attending p	Physician/Me		B □Ectopic pregnancy		23d. Date of deliver Month	y Day Year
.O.	the at	ysici	1 Yes 2 No 9 Unknown	Other (specify)			
٥.	that the de ned by the a detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	
rds,	quires en sign				1 ☐ Yes	2 No 3 Proba	ibly 4 Unknown
of Vital Record	e law requ has been je 2 shoul	Completed			24a. Was an autopsy	prior to com	sy findings available pletion of cause of
E B		Con			performed 1 ☐ Yes 2		2 🗆 No
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 No  Hospital: 1 □ Inpatient 2 □ ER/Outpat	Out The same of th	th <i>(Check only one)</i> ome 5 ☐ Residence	e 6 Other (Specify)	)
	g Phys er this eral di	⊢	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how		
ion	ath. or: After	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			O oto Months
Division	l or Attendi after death. Director: A J in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S	et and Number or Rural State)	Houte Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier (Check only (Check only 2) Medicel Examiner: On the basis of examination and/or	eath occurred at the time, date and place	, and due to the caus	se(s) and manner as sta	ated. the cause(s)
	To the Howithin 24 To the Fu	ledical	one) and manner stated.				
	vit To Con	Σ	29b. Signature and title of certifier	D3064	-1 5	Ententes	26 2004
•	4		30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number  D3064  De, Print)  Set Clin Chy Ai	10 Rr	1 france	rayland
	V		12 Manic (L. Sabapalli, 3400  31. Date filed (Month, Day, Year)  32. Megistrar's Signature	crumun giv	128	( / 0 / - (	2/2/9
:	St Regist	ate rar	SEP 2 2 2004	parti			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 18 2004 **Physician** Milton Rieh1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel North Arundel Hospital Glen Burnie If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1√2M 2□F 213-16-5620 Oct. 15, 1909 Director 94 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Pasadena Funeral Director Anne Arundel Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number United States 21122 8033 Long Hill Road death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify. Specify: White þ 3 ₩idowed 4 Divorced Completed 18b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Law other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be t of Health and Mental. 1 and 2 should be Sophia Fuchs Louis Riehl 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 1010 Somerset Drive Ms. Josefa Suppes / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 20, 20a. Method of Disposition Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. ö 2004 Catonsville, MD \* 4 □ Donation Metro Crematory 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Appropriate Cause of the Cause o bar Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic prepnancy Year ŏ in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by signe be 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 20 1 Tyes 2 ER/Outpatient 3 DOA this Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Deat Medical Certification: Natural 5 Pending 2 Accident 2 🗆 No death. investigation 1 ☐ Yes 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Momicide within 24 hours a To the Funeral ( Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ess of person who completed cause of death (Item 23a) (Ty den Burno.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Box 68760.

P.0.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death er 16, 2004 **Physician** September 8:45 PM Roos Elizabeth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery 7108 Clarden Rd. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan • 28, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 T F Ĩ919 85 475-09-2001 Minnesota Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show other treumatic event, the Medical Examiner must be notified at Bethesda 1 ☐ Yes 2XXNo Montgomery Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20814 United States 7108 Clarden Rd. items 23e Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 0 Specify: White Specify: 3 TWidowed 4 ☐ Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Heelth and Mental Hygiene. Int: if Item 27 ie marked other than ' Elementary/Secondary (0-12) Colfege (1-4or 5+) Linguist International Org. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edith Drake Harold Waldon Briggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5212 Flanders Ave., Kensington, MD Catherine R. Selden / Daughter Department of Heelt Importent: if Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept Date 21 20c. Location - City or Town, State 1 ☐ Buriaf 2 X Cremation 3 ☐ Removal from State \* 4 Donation 5 Other (Specify) 2004 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Rapp Funeral and Cremation Services Sex Johnson 20910 - M00382 933 Gist Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) LUNG **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 robably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No or Attending Physicien: funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Tes 2 Z NO 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ofter death Director: / the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only onel and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitte @13818 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Gary Fisher, M.D.;

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

5530 Wisconsin Ave. #730, Chevy Chase, MD
32. Physistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 200 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1:30 A N September 20, Hugh Rose 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 112 D Cross Keys Road Baltimore N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 20, 1920 5. Social Security Number 9. Birthplace (State or Foreign 6 Say 7. Age (In vrs. last birthday) **Funeral** 1**∑**M 2□F 84 Yrs. England Director 335-36-4663 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Maryland Eventure. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No **Funeral Director** Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 112 D Cross Keys Road 21210 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) College Professor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Rose Anne Ogus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Jon Plaunick 113 Forge Haven Drive, Perry Hall, MD 21128 (cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/21/04 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 1 July 13 Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of head failure. List only one cause on each line.

Immediate glause Enal disease or condition resulting in death)

a. BLADDER CANTR — METACOTATION CONTROLLED TO STATE AND CONTROLLED TO STATE 9705 Belair Rd., Baltimore, MD 21236 Approximate Interval Between Onset and Death 23 YEARS **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequença ori attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ONGESTIVE HEART FAILURE 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy perform 1 ☐ Yes 2 🗷 of Vital To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie use of death (Item 23a) (Type, Print) RD SUME 200 LUTHER VILLES MO 31. Date filed (Month 32 Registrar's Signature State Registrar

	ľ	State of State of Registrar	Maryland / Dep G835 9/29/2	artment of Health and Hifi <del>cate</del> of Death	Mental Hygie	ne № 111 20077
		Decedent's Name (First, Middle, Last)		A	2. Date of Death	Day Year
Physici /Medic		Christopher	Ric	hardson Jr.		ER 14, 2004 2:20 P
Examir		4a. Facility Name (If not institution, give street and num UNIVERSITY OF MD SHOCK		4b. City, Town, or Location of De BALTIMORE CITY	ath	4c. County of Death
Funeral Director		219-23-1176 <sup>1万M 2□F</sup>	7. Age (In yrs. last birthday 15 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		9. Birthplace (State or Foreign Country) MD
and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
with the Maryland a or 28a-1 show be notilied at	ō	MD NA	Baltime	oro		XXYes 2 □ No
128a-	Director	10e. Street and Number	Daltim	10f. Zip Code	10g.	Citizen of What Country?
death with	Funeral D	1014 East Belvedere  11. Marital Status 12. Was Dece		21212 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	U.S.A.  14. Race - American Indian,
ē <b>≗</b> ≅	þ	Mever Married 2 Married 1 Yes, Giv.  3 Widowed 4 Divorced Year or Da	XIXNo	↑ Yes 2 No Specify:	anto rican, etc.,	Black, White, etc.  Specify: Black
72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-	(Give	dent's Usual Occupation kind of work done during most of ห DO NDT use retired)	rorking 16b	o. Kind of Business/Industry
ind 212: be filed within tal Hygiene. d other than evant, ILE M	ပ္ပ	10th grade na		Student		School
Iryland 212: should be filed within nd Mental Hygiene. marked other than imatic evant, the M	To Be	17. Father's Name (First, Middle, Last)  Michael Burnside		Kimber		ard-Burnside
Aar 2 sho 1 and 1 sm	8	19a. Informant's Name/Relationship (Type, Print)	other 19b. Maili	ng Address (Street and Number or	Pural Route Number, Cit	ty or Town, State, Zip Code)
a an an an an an an an an an an an an an		Kimberly R. Howard=B  20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from S	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 20c.	. Location - City or Town, State
Itimen ritmen ri		* 4 ☐Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	King Mer	norial Park 9/	25/04 Ra	ndallstown, Md
Baltimore permit. Pages 1 Department of H Important: If ites any Injury or ott		239 Part 1. Enter the disease, or complications that co		2 Name and Address of Facility March F/H West 1300 Wabash Av		ore, Md 21215
Physician		Shock, or fleatt failure. List only one cause on ea	IGIT INTO.	shot wounds	ac or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	or as a consequence of):			
	iner	Sequential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o. as a consequence of).			
8760, —	dical Examiner	that initiated events c.	or as a consequence of):			
Records, P.O. Box 61 The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as i	Physician/Med	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
cords, P.	by	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	ouse contribute to the cause of death?  2 🌣 No 3 🗆 Probably 4 🗀 Unknown
Division of Vital Records, or attending Physician: The law requires taller death.  Director: After this certificate has been signe in by the funeral director, page 2 should be or	Completed				24a. Was an autopsy performed 1 X Yes 2	
Vita	Be (	25. Was case referred to medical examiner?			eath (Check only one)	
of Vita Physician: rthis certific ral director,	2	1   Yes 2   No Hospital: 1  In Ir	patient 2 ER/Outpatie		Home 5 Residence	
on o	on:	1 - Indicates o - I origing	f Injury n, Day Year) 28b. Time o Injury	Work?	28d. Describe how in	
Vision Attanding r death. actor: After	cat	2 Accident investigation 9-13 3 Suicide 6 Could not be	10-00	PM 1 □Yes 2MNo	Subject V	
Divi	Certification;	determined 200.1 laco	of Injury - At home, farm, sti g, etc. (Specify)	*	City or Town, Sta	and Number or Rural Route Number, ate) 2827 W. North Ave
Divisio  To the Hospital or Attandi within 24 hours after death.  To tha Funaral Diractor: A completely filled in by the fu	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the ba and mann	sis of examination and/or in	h occurred at the time, date and pla- vestigation, in my opinion, death oc-	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
To t withi To ti	Σ	29b. Signature and title of certifier		29c. License number	e L	Date signed (Month, Day, Year)
÷ 12		high him mit		OCME		PTEMBER 15, 2004
1		30. Name and address of person who completed cause $\angle$ ( $NG$ $\angle$ $I$ . $M$ $P$			et, Baltimor	re, Maryland 21201
Sta Registr		31. Date filed (Month, Day, Year) 32. Re SEP 2 2 2004	gistrar signature	Specter		

04-05548 CLAUDE RUSSELL WHM

M 		1 - State of Maryland 11 - State of Maryland 11 - State of Maryland 12 - For Amend 11 - State of Maryland 12 - For Amend 11 - State of Maryland 12 - For Amend 11 - For Middle 12 - For Maryland 12 - For Amend 11 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Middle 12 - For Maryland 12 - For Mar		1/23/04 <sup>e</sup> tas taseg, No. 1 2 3 7 8 ate of Death 3. Time of Death
Phys		1. Decedent's Name (First, Middle, Last)  - Claude Russell Claude Rus	M	onth Day Year UGUST 27, 2004 7:39 P
	dical niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
~		4200 Blk EASTERN AVE  5. Social Security Number unk 6. Sex 7. Age (In yrs. last bit	BALTIMORE CITY  thday) If Under 1 Year   If Under 24 Hrs. 8, Da	ite of Birth 11nk 9. Birthplace (State or Foreign
Funer Directo		1 ☑ M 2 ☐ F unk	Yrs. Months Days Hours Min. (M	ate of Birth (State or Foreign Country)  9. Birthplace (State or Foreign Country)  unk
ith the Maryland or 28a-1 show	tor	10a. State UTK 10b. County UNK 10c. City, Tow	n or Location	unk 10d. Inside City Limits unk □ Yes 2 □ No
th with the 23a or 28s	ai Director	10e. Street and Number	unk 10f. Zip Code u	nk 10g. Citizen of What Country? USA
Ind 21215-0036  be filed within 72 hours after death with the Maryland Ital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notilised at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes 2 No It Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Young of Yes, specify Cuban, Mexican, Puerto Rican,  1 □ Yes 2X No Specify:	es or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: white
21215-0036 of within 72 hours aft giene, ar then "natural; or the Medical Exert	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  unk  16a  College (1-4or 5+)  unk	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	unk 16b. Kind of Business/Industry unk
	To Be Co	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name (First	, Middle, Maiden Sumame) unk
re, Maryla s 1 and 2 should I Health and Men item 27 is marke other traumatic.		O.C.M.E.	. Mailing Address (Street and Number or Rural Rout 11 Penn Street Baltimore	
Pages nent o ant: If i		1 □ Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 🛛 Other (Specify) in state	f Disposition (Name of pate ry, crematory or other place)	20c. Location - City or Town, State
Balt permit. Departit Importi	ouce.	21. Sign Lung - Funeral Service Licensee de Mirector	State Anatomy Board 655 Baltimore, MD 21201	5 W. Baltimore Street
> Physicia	_	23a. Pant Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Heroin Intoxic resulting in death)		iratory arrest, Approximate Interval Between Onset and Death
/Medica	er	Due to (or as a consequence Sequentially list conditions.		
ecuted and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Citizes of Injury that initiated events consulting in death) Last Due to (or as a consequence consulting in death) Last Due to (or as a consequence consulting in death).		
68760, ficate be executed physician and sthe burial-transit	edicai E	d.		
Box 6 auth certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
rds, P.O. quires that the done signed by the uld be detached	þ	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I. 23	3e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 Æ Inknown
of Vital Records, hysician: The law requires the sertificate has been signed idirector, page 2 should be continued.	Completed			ta. Was an autopsy autopsy findings available prior to completion of cause of death?  ▼ Yes 2 □ No 125 Yes 2 □ No
Vita iclan: certific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Chec	
on of ding Phys h. After this funeral dir	lon: To	27. Manner of Death  1 Natural 5 Pending  Routh (th. Day Year)	Firme of 28c. Injury at Work?	Residence X Other (Specify) SCINE
Division of To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the tuneral d	Certification:	2 Accident 3 Suicide 4 Homicide  investigation 8/27/04  28e. Place of Injury - At home, fa building, etc. (Specify)  Scene	rm, street, factory, office 28f. Lo	cnown cation (Street and Number of Bural Route Number by or Town, State 1200 Eastern Ave.
Hospital 24 hours Funeral tely filled	Medical Co	29a. Certifier  (Check only one)  1 □ Certifying Physician: To the best of my knowledge 2 ☑ Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place, and due	e to the cause(s) and manner as stated.
o the vithin 2	Mec	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Priseo		> Cuety-	OCME	AUGUST 28, 2004
		30. Name and address of person who completed cause of death (Item 23a)  ANA RUBIO, MD	(Type, Print)	
Regi	State strar	31. Date filed (Month, Day, Year)  SEP 2 2 2004  32 Registrar's Signature	Sperte	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Supriya Roy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Birthplace (State or Foreign Country) 7. Age (In yrs last birthday, 5. Social Security Number 6. Sex **Funeral** 1**X** M 2 □ F Days 213-68-7459 India Director 68 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If item 27 le marked other than "natural", or Items 23e or 28e-f show or other traumetic event, the Madical Examiner must be notified at 1 ☐ Yes 2X No by Funeral Director Baltimore Maryland Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1320 Denby Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Asian Indian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Washington Suburban 1 and 2 should be filed within Health and Mental Hygiene. em 27 le marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Electrical Engineer Sanitary Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kalipada Roy Kamala Sen Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: If item 27 le any injury or othar trau once. 1320 Denby Road Towson, MD 21286 <u>Shubha Roy/Wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 9/22/04 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signatur Funeral Service Lipensee MacNabb Funeral Home, Edward Gregorchik 301 Frederick Road Cáto, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, A 301 Frederick Road Cátonsville, MD 21228 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Dug to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit To the Hospitel or Attending Phyelclan: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 1 ☐ Yes 2 ZNo Medical Certification; To 2 ER/Outpatient 3 DOA ate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 2 No 1 TYes investigation Director; / Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of centries 561011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32/Registrar's Signature State SEP 2 2 2004 Registrar DHMH 17 Rev 1/2001

			For 1 _ State	State of Ma	•			lental Hygien	е	
			Registrar		Ce	rtificate of L	Death	Reg. N	SUUL	29980
	Physicia	an	Decedent's Name (First, Middle, La	,				2. Date of Death Month Da	ay Year	3. Time of Death
	/Medic			mont	Spence			September	20 2001	<u></u>
	Examin	er	4a. Facility Name (If not Institution, giv		- 1 (	4b. City, Town, or		4	c. County of Deal	th
_			5. Social Security Number 6. S	iorial Hos	(In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth	N/A	thplace (State or Foreign
	Funeral Director		238-70-8365	M 2□F	57 Yrs.	Months Days	Hours Min.	(Month, Day, Year	)   Co	ountry) Garolina
			Usual Residence of Decedent		<u> </u>	1		Jun 27, 10	14 / 1000	in account
	ylang		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f s	cto	Maryland NIA	<u> </u>	Baltu	more Ci	+4			1 Yes 2 No
	or 28	Oire	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	
	23a	ra		lvert Stre		212			us.	1
	er de	Funeral Director	11. Marital Status	12. Was Decedent En Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 No	Specify:		Specify: B	lack
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Hems 23a or 28a-f show the Medical Examinat must be notified at	ed	15. Decedent's E	ducation	16a. Dec	edent's Usual Occupa	tion	16b. I	Kind of Business	/Industry
215	nin 72 in "in	Completed	(Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4or 5+	life.	e kind of work done d DO NOT use retired)	uring most of worki	ng		
2	d wit	Con		4	T J	anutor			anitor	rial
5	oe filed al Hygi d other event, L	Be (	17. Father's Name (First, Middle, Last				18. Mother's Name	(First, Middle, Maide	n Sumame)	
Maryland	Meni Meni Marke Marke	은	Kenneth S		- Spen	cer	Elizal		hn so	n
Jar	l 2 sh n and ls m reum	1	19a. Informant's Name/Relationship (					al Route Number, City		
	1 and Health Sm 27 ther t		Elizabeth S	sencer	20b. Place of Disp			Date 20c. I	ocation - City or	gan 48602 Town State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinat must be notified at once.		1 Burial 2 Cremation 3		cemetery, cre	amatory or other place	)			
를	it. Partiment injury		<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lices</li> </ul>		Metro	Yemutur 2 Name and Addres	Y DEAT -	14,2004 Ba	itemore	Co. 140,
B	Departing any in		Ronalda	Grainen	,	Ronald	A. GARAY	En Funer	al Han	21201
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused in	the death. Do not er					Approximate Interval Between
J	Physician		Immediate Cause (Final disease or condition			a Hem	orrhei	13 60		Onset and Death
	/Medical		resulting in death)	Due to (or as a	Cerebra consequence of):	a run	DITTIEL	3		5 May 5
я	Examiner		Sequentially list conditions,		nonia					5 days
	ad sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					0
	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
38760,	icate be executed physicien and s the burial-transit	dicai		d						
68		0								
Вох	death certifi e attending I id for use as	an/N	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic pregnancy			23d. Date of del	
B	0 0 0	Physician/M	in the past 12 months?	4☐Pregnant at t		Other (specify)			Month	Day Year
P.O.	law requires that the de as been signed by the a 2 should be deteched t	Phy	9 Unknown					00 5/44		
	res th igned be d	by	Part II. Other significant conditions	contributing to death but	it not resulting in the	underlying cause give	n in Part I.			o the cause of death?
ecords,	w require been si should I	ted						1 185 2	2010 3017	obably 4 Bolikilowii
ec	elaw hasb je 2 sl	Completed						24a. Was an autopsy performed?		topsy findings available completion of cause of
a B	The sage							1 ☐ Yes 2 ☑ N	o 1 ☐ Yes	2 12 No
Zi.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		(Check only one)		
o	Phys r this ral di	- To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	y 28b. Time	of 28c. Injury	4 ☐ Nursing Ho	me 5 Residence 28d. Describe how inju		cify)
Division of Vital	Attending Physicien: r death, ector: After this certifica	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work	? ′es 2 □ No		,	
/isi	ten for the	ifica	3 Suicide 6 □Could not b	28e. Place of Injur	ry - At home, farm, s	treet, factory, office		28f. Location (Street a		ural Route Number,
ă	2 5 5 C	Certification:	4 Homicide	building, etc.	. (Зреспу)			City or Town, Stat	(8)	
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	100	29a. Certifier 1 Certifying Pl	nysicien: To the best of miner: On the basis of	f my knowledge, dea	th occurred at the tim	e, date and place,	and due to the cause(s	s) and manner as	stated.
	the H iin 24 the F	ledic	one)	and manner stat	ted.					
L	To To	Σ	29b. Signature and title of certifier  Jecelyne Kou	atchou 1	ND	29c. License			ate signed (Monti	
•	^		7.000			ATZ	43894	6 Sep	ember,	w, we
	)	- 1	Joeelyne Kou 30. Name and address of person who Joeelyne Kou ATC	completed cause of de	eath (Item 23a) (Type East Univer	gify Boule	evard,	Baltimo.	re, m.	D 21218
	Sta		31. Date filed (Month, Day, Year)	32. Registra	4- 0'					
	Registr	ar	SEP 2 2 2004	Denger	P	ports				

State of Maryland / Department of Health and Mental Hygiene For State Registra 2998 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPT **Physician** 16, Spain 2004 6:12 PM Rodnev /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health Of Catonsville Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4-20-57 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Days **Funeral** Hours Min. 1**∑**M 2□ F 47 Baltímore, Md 212-70-6712 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b County "natural", or items 23a or 28a-f show ital Hygiene. od other than "natural", or Items 23s or 28s-f shov svent, the Medical Examinar must be notified at Yes 2□No by Funeral Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 609 Allendale St. 21229 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: Specify. Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carr Lowrey Glass Manage Glass Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fill trent of Health and Mental Heart: If itsm 27 is marked out jury or other traumatic even Earl Spain Barabara Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 609 Allendale St. Baltimore, Maryland 21229 Theresa Spain Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If sny injury or once. Kings Mem. Park 9-21-04 Randallstown, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Ser, P.A.
1300 Eutaw Place, Baltimore, Md. 21. Signature of Funeral Service Licensee Lloyd M. Esten

23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Colon cancer **Physician** 4415 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by been signe should be o 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient To Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Naturai 2 Accident 5 Pending Nithin 24 hours after death.

To the Funeral Director: Aft 2 🗀 No 1 Tyes investigation 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D005' 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENG OSEI-BOAT K WABENA 32. Registrar's Signature 31. Date liled (Month, Day, Year) State Registrar

		-	1 = For State Registrar	State of Mar		artment of H		-	giene Reg. No.	20092
			Decedent's Name (First, Middle, Las	it)				2. Date of De	ath	3. Time of Death
	Physicia /Medic		Yvonne	J.	Stewart			Month 9	18 2004	3:15 p. M
3	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		th	4c. County of Dea	th
	Funeral		855 Lenton Ave.  5. Social Security Number 6. Se	ex 7. Age	(In yrs. last birthday)	If Under 1 Year	imore If Under 24 Hrs		th 9. Bir	thplace (State or Foreign
n	Funeral Director			□M 2 况 F 6	3 Yrs.	Months Days	Hours Min	. (Month, Da	y, Year) C	A1
	pur &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation		<u> </u>		10d. Inside City Limits
	Maryli f sho	ō								M∑Yes 2□No
	r 28a-	Director	Md N/A  10e. Street and Number		Balto	10f. Zip Code			10g. Citizen of What C	ountry?
	th with	alD	855 Lenton Av	venue		212	12		USA	
	er dea	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puel	Specify Yes or No rto Rican, etc.)	14. Race - Am Black, Whi	
36	irs aft	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,	1 ☐ Yes 2 ☐XNo	Specify:		Specify: P	lack
21215-0036	within 72 hours after death with the Maryland ene. Than "naturel", or items 28a or 28a-f show he discut Examilian man man be mailfied at	ted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	dent's Usual Occupa kind of work done d	ition furing most of we	orkina	16b. Kind of Business	/industry
21	han "r	Completed	Elementary/Secondary (0-12)	MaSter (1+4or 5+	Direc	DO NOT use retired, tor of Pe	)	,,,,,,,,	Spring G	rove
N	filed w Hygier other th		12th grade  17. Father's Name (First, Middle, Last)	Degr	ee		18. Mother's Na	me (First, Middle,	Hospital Maiden Sumame)	
and	should be t nd Mental t markad ol	To Be	William Morgan Ja	ackson				Haygood	,,	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healih and Menth Hygiene. If them 27 is marked other than "naturel; or items 23a or 28a-1 show if it then 27 is marked other than "naturel; or items is used by notified at or other treumatic event, the Medical Exacting the relation at	-	19a. Informant's Name/Relationship (7	,, ,		*			er, City or Town, State,	Zip Code)
6, ₹	1 and Health em 27 ther tr		Kimberly Stewart  20a. Method of Disposition	- Daughter	2/19 20b. Place of Dispo		rt Stree	Date Dallo	, Md 21218	Town State
TOL	bages ent of I nt: if it		1 Burial AXCremation 3 :		cemetery, cre	matory or other place Crematory	0_2	1-2004	Catonsvil	
Baltimore,	permit. Pages 1 and Depertment of Heali Important: if item 2 any injury or other once.		21. Signatur of Funeral Service Licen		2:	2. Name and Addres	s of Facility	Balt	imore, Md.	21215
_	8 Q E # 9		xonala v.	Frugue _		March F. I		4300 W	labash Ave.	A
			23a. Part1. Enter the disease, or compensations, or heart failure. List only limited the Cause (Final	one cause on each line	).					Approximate Interval Between Onset and Death
	Ph <sub>y</sub> sician /Medical		disease or condition sulting in death)	a. Heute Due to (or as a b. Non - Ho	consequence of	enous L	euken	nria -	P14	1 year
Н	Examiner		Sequentially list conditions,	Non-Ho	dakin's	Lympho.	ma C	hemoto	lerapy	1/2 years
7	asit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	/ /	8		• /	·
	and nand ial-trar	Exan	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
8760,	cate be executed physician and the burial-transit	dlcall		d						
9	ertifica ling ph e as ti	Med	IF FEMALE:	00- 11	(					
Вох	deeth certifica e attending ph od for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
0	0 0 2	hysk	1 ☐ Yes 2 M No 9 ☐ Unknown	9□ Unknown						
S, P	Se U. 0	by P	Part II. Other significant conditions c	ontributing to death but	not resulting in the u	nderlying cause give	n in Part I.		obacco use contribute to	
ord	w require been sig should t	ted						1 🗆 '	Yes 2X No 3∏P	robably 4 □Unknown
Vital Record	2 S C	Completed				-		24a. Was autop	an 24b. Were a prior to death?	utopsy findings available completion of cause of
alF	Th ate pag	e Col	DE Man and address to modical					1 ☐ Yes	2XNo 1 Yes	2 No
Ž	Physicien: this certific ral director,	0 8	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	t 2 ER/Outpatie	nt 3 DOA Othe	\r	eath <i>(Check only c</i> Home 5 Resi	dence 6 □Other (Spe	cify)
6 ر	ng Phy ter thi	n: T	27. Manner of Death  1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day	28b. Time o	-	at		how injury occurred	
sioi	Attending or death. ector; After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	Tax .		
Division of	i or At after o Direct I in by	Certification:	4 Homicide determined	building, etc.	y - At home, farm, st (Specily)	reet, factory, office		City or Tou	Street and Number or R wn, State)	urai Houte Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	(Check only 2 Medical Exan	niner: On the basis of e	examination and/or in	h occurred at the tim vestigation, in my op	e, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	o the rithin 2 o the omplet	Med	29b. Signature and title of certifier	and manner state		29c. License	number		29d. Date signed (Mont	h, Oey, Year)
1	->-0		1/2			Do	0591	1/3	September	th. Oby. Year) Fr 21, 2004 50 ORCEAS ST RE 21231
	in		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)				50 00064-0
	רן		LODE J. Se	WINNEN 32 Enjetrar	Signature	S HEPKIN	5 ONCO	1054 C	RATER 16	SU UKULAS SI
	Sta Registr		31. Date filed (Month Day, Year) SEP 22 2	004 Seeces	o Signatore	reales			127011101	-21-31

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day
September 3, **Physician** 2004 1:15 PM<sup>M</sup> Joan P. Shindledecker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7315 Alvah Avenue **Baltimore** Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 31, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs. 52 July Director Maryland 212-58-4452 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avent, the Mudical Examiner must be notified at 1 ☐ Yes 2√ No MD Baltimore Baltimore Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 7315 Alvah Avenue 21222 USA or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumate. 1 Yes 2 2No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 12 0 administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Otto Wolf Wilma Ruth Pencek ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilma Wolf/mother 7311 Alvah Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 X Donation 5 ☐ Other (Specify) Funeral Servic Licensee ROHALD S. W. 22. Name and Address of Facility once State Anatomy Board 655 W. Baltimore Street Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) tensia curter /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter choosing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery for 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ 1Ño director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Alter Natural 5 Pending investigation 1 Yes 2 No death. 4 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/9/2004 20 040854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jom Hack Ruseberg 51 91503 301 Dung MD St Parl

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

SEP 2 2 2004

32. Ragistrar's Signature

		1 - For State Registrar	State of Maryland / De	ertificate of Death		g. No. 1	00001	
_		Decedent's Name (First, Middle, L.			2. Date of Death	1 == \( \frac{1}{2} \\	3. Time of Death	
Physic /Medi		Gerald	ine M. Scripter		Septembe	er 19, 200	4 1:16 A <sup>M</sup>	
Exami		4a. Facility Name (If not institution, g	•	4b. City, Town, or Location of Death	1	4c. County of Dea		
		Suburban Hospit  5. Social Security Number 6.	3.1 Sex 7. Age (In yrs. last birthda	Bethesda  v) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgome		
Funeral Director		363-24-5856	1 ☐ M 2 五 F 88 Yrs.	Months Days Hours Min.	March 2,	1916 Mi	thplace (State or Foreign buntry) chigan	
		Usual Residence of Decedent	toe City Town					
Department of nearlit and Menhal righene. Importent: If Itam 27 is marked other than "natural", or Items 23a or 28a-1 show yilling or other treumatic event, the Madical Examinational De notified at once.	2	10a. State 10b. County	10c. City, Town or	nd Hill			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
28a-1	Director	Virginia Loudous  10e. Street and Number	ı Kou	10f. Zip Code	10	g. Citizen of What Co		
Sa Or	ä	20445 Woodtrail	Road	20141		United Sta		
E B	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame		
9		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☑ No Specify:	o nican, etc.)	Black, Whit		
LEX	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		1.	***	hite	
200	Completed by	15. Decedent's (Specify only highest g	rade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wor b. DO NOT use retired)	king	6b. Kind of Business	rindustry	
I'M N	mo	Elementary/Secondary (0-12)	College (1-4or 5+) Sa1	es Clerk		Department	Store	
vent,	a l	17. Father's Name (First, Middle, Las	st)		ne (First, Middle, M	laiden Sumame)		
atic e	To B	George W. Clark		Edith	Ward			
enm,		19a. Informant's Name/Relationship		illing Address (Street and Number or Ru				
har t		Faith E. Jarvis/I		45 Woodtrail Road, F	Date 2	1, Virgini Oc. Location - City or		
or of		1 ☐ Burial 2 🖸 Cremation 3	Literilovai iloili State	b. Place of Disposition (Name of cometary, crematory or other place)  Sept. 20,  Sept. 20,  Bethesda, Maryland				
injury		<ul> <li>4 □ Donation 5 □ Other (Spec</li> <li>21. Signature of Funeral Service Lic</li> </ul>						
any is		Rayter	M00198	22 Name and Address of Facility Obert A. Pumphrey 557 Wisconsin Ave.,	Funeral Retherda	Home/ Cha	sda-Chevy se, Inc.	
		23a. Part1. Ent of the disease, or co shock, or seart failure. List on	implications that caused the death. Do not e				Approximate Interval Between	
ician		Immediate Cause (Final disease or condition	Peritonitis				Onset and Death  1 day	
ical iner		resulting in death)	Due to (or as a consequence of):					
	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):					
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ror use as me to	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of del Month	ivery Day Year	
בווכת וכו כפם שם חום מ	ysician/M	23b. Was decedent pregnant	1 Live birth 2 Fetal death	B □Ectopic pregnancy 5 □ Other (specify)				
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State Registrar

Amit Rajvanshi, M.D.
31. Date filed (Month, SEPar 2 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D37891

121 Congressional Lane #409, Rockville, Maryland 20852
32. Residents Signature

September 19, 2004

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

				State of Ma	aryiand	-			neaim an Death	iu ivierilai		-0.0	01	00000
			Decedent's Name (First, Middle, L.)	ast)			uncal	0 01			of Death		114	3. Time of Death
	Physicia			,						Mon SEPT	-	Day	Year	A.AO DAG
illia	/Medic		BOOKER T. SPRIGGS 4a Fecility Name (If not institution, g						4b. City, Town	, or Location of			004 ty of Death	4:40 PM
1	Examin								BALTIMO			N/A		
_			FUTURE CARE HOMEV 5. Social Security Number 6.		e (In vrs. la	st birthday)	If Under				of Birth		9. Birtho	place (State or Foreign
	Funeral Director		214 24 7902 Usuel Residence of Decedent	<b>Ж</b> М 2□ F		4 Yrs.	Months	Days	Hours			1930	Cour	ntry)
	uth with the Maryland 23e or 28e-f show ust be notified at	_	10a. State 10b. County			Town or Loc	cation						1	0d. Inside City Limits 1 X Yes 2 □ No
	M 96-1	Director	MD N/A		2121	8	40/ 7:	0.4			10	g. Citizen of	March Cour	
	it to	吉	10e. Street end Number				10f. Zip						WHAT COU	ury?
	ath v	rai	401 E 25th STREET		F	1 40 14	212		lianania Oriaia	2 (CH. V		.S.A	ice - Americ	oon Indian
20	hours efter death with the Maryland urel; or flems 23e or 28e-f show at Examiner must be notified at	by Funeral	11. Maritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 XYes 2 1 If Yes, Give Year or Dates:	No				an, Mexican, F	n? (Specify Yes Puerto Rican, e	tc.)		ack, White,	etc.
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21215-0020	in 72	Completed	(Specify only highest g	rade completed)		(Give I lite. D	kind of wo OO NOT u	rk done se retire	during most of d)	f working				•
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	Hygin Hygin ther with the wild had been stated to the stat		17. Fether's Name (First, Middle, Las	st)					18. Mother's	Name (First, I				
Maryland	d be so contained to contain the contained ton	o Be	BERNARD SPRICE	GS					EI	HTIC				
2	shoul mari		19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street	and Number of	or Rural Route	Number,	City or Town	n, State, Zic	Code)
Š	ith ar		TALMADGE ELLERBE			3000 E	YOUGO	ATE	TATE TO	ALTIMOR	E M	AT TURE	m 211	206
a)	Heal Heal tem 2		20a. Method of Disposition	(SIEFSON)_	20b. Pla	ace of Dispos	sition (Nar	ne of		Date	2	ARYLAN Oc. Location		
ᅙ	Pages lent of int: if its		1 ☑ Burial 2 ☐ Cremation 3			metery, crem				SEPT.	22	2004	hal+	MD
Baltimore,	artme ortani Injury	- 1	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Or it t				ess of Facility					JNERAL HOME
Ba	pamit. Departm Importa any Inju		21. Signaturo i di ci a socialisti	34										YLAND 21213
			23a. Part1. Enter the diseese, or co shock, or heart failure. List on	mplications that caused	I the death.	Do not ente	er the mod	e of dyi	ng, such as ca	rdiac or respira	tory arres	st,	1	Approximate Interval Between
A. C.	Physician /Medical		Immediate Ceuse (Final disease or condition	Pen	SK()	made	R	A-	hial	Filor	llo	utran		Onset and Death
	Examiner		resulting in death)	a	Due to (of	as a consequ	uence of):						1	
7	D =	ner	000	. Do	abor	to c.								
1.7	outec	Examiner	Sequentially list conditions,	1 b	Due to tor	as a consequ	uence d).						i-	
o	a axe an a urial-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	m	X	Ren	ial	I	hand	Lie	Erma	ų l	
68760,	aath certificate ba axecuted attanding physician and for use as the burial-trensit	Ical	that initiated events resulting in death) Last	C	Due to (or	as a consequ	uence of):	400			1		7	
	ng ph as t	Medi	Todaking in doubly East	ile.	pa	tru.	En	. C.L.	ma	60 120	ath	Al.	1	
Box	th ce andii r use	ary		d	100	100		100	1	)		1	1	
	daa he att	Sici	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the un	nderlying o	ause gir	ven in Part I.	238	. Did tob	acco use co	ontribute to	the cause of death?
0.0	that tha dag ned by the a datached f	/ Physician/M	· Right.	side t	ka	vt	Fu	h	2		1 🗆 Yes	2 □ No	3 ☐ Prol	bably 4 Tonknown
Vital Records,	requiras reen sign hould be	Completed by	with Ser	se In	cus	md	30	gur	pelat	24a	. Was an perform		ava	ere eutopsy findings ailable prior to mpletion of cause death?
= Re	The ler ata has page 2	Comp	· Chrone	Postine	twe	· Pn	Inu	you	Pis	a	1□ Yes	2 No	1[	Yes 2□ No
<b>E</b>	San: Brtific Sctor,	Be	25. Was case referred to medical examiner?					1~		Death (Check				
<del>o</del>	5 000	2	1 ☐ Yes 2 ☐ 1√0	1		R/Outpatient				ing Home 5				y)
	ding P. h. Aftar t funera	ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		8c. Inju Wo			icnoe nov	v injury occu	irrea	
<u> </u>	Attending or deeth.  octor: Aftai by the fune	cati	2 Accident investigati 3 Suicide 6 Could not	h a			М		Yes 2□No		(0)		1 0	10 N
Division	frect frect n by	Certification:	4 Homicide determine	28e. Place of Injuding, etc	ury - At hor c. <i>(Specify)</i>	ne, rarm, stre	et, ractor	, office			or Town,		uer or Hura	al Route Number,
	rato led i	ပီ												
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	edical		Physician: To the best of miner: On the basis of and manner sta	examination									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0			29	c. Licens	se number		29	d. Date sign	ed (Month,	Day, Year)
	F 5 F 0		Dava	w	V	MD		D	3146	4		9/2	710.	7
	. 1		30. Neme and address of person wh	completed cause of d	eath (ftem	23a) (Type I	Print)							1
	4+		SHOAIIS A.	HASH	mI	MD	5	2(	N, En	Jan (	4	nte 3	of 1	July. m) 2
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2. 2.	2004 32. Registra	ars Signati	J G	1	200	41					

Patriont known as BETH STIEFEL-ITOH

			1 - State Registrer AMEND ITEM 3	State of Maryla 19a PER FH	G835 Ce	artment of 122.04 JI Itilicate of	Health and <sup>I</sup> Death		giene Reg. No.	01.	00000
	Physici		Decedent's Name (First, Middle, Last)     BETH	E		STIEFEL-		2. Date of De Month Septem	Day	Year , 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of De			nty of Death	<u> </u>
			Sinai Hospital	ot Backines		Baltin		ty		N/A	
Ŀ	Funeral Director		190-42-8443	M 2 F 7. Age (In y	rs. last birthday) Yrs.	Months Days			1950	9. Birthpla Country	ce (State or Foreign  PA
	and and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				100	d. Inside City Limits
	a-f she	ctor	MD BALTIMORE	0	WINGS M	ILLS					1 □ Yes 2 No
	vith the	Funeral Director	10e. Street and Number	COURT		10f. Zip Code	7			of What Country	y?
	ns 238	erai	3501 STONEY CREEK  11. Marital Status	2. Was Decedent Ever in	U.S. 13.	2111 Was Decedent of		(Specify Yes or No	U.S.A	ace - Americar	n Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinant has been collided.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cu 1 ☐ Yes 2 🛣 No		(Specify Yes or No erto Rican, etc.)	Spec	lack, White, et cify: WHIT	
15-0 -	*natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occu kind of work done DO NOT use retir	e during most of v	vorking	16b. Kind of	Business/Indu	stry
212	d within giene. r than "u	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		.L. TEAC	•		EDUCA	TION	
pul	be filed ital Hygi id other event, I	Be	17. Father's Name (First, Middle, Last)	DΤ	STIEFEL			lame (First, Middle,		ame) SPRITZL	ED
Maryland	should and Men marke	ပ	HAROLD ROBE			ng Address (Stree	JACQUE	LINE Rural Route Numb			
	and 2 sealth ar n 27 is		TSUTOMU STIEFEL-IT	<del>OH</del> /HUSBAND	3501	STONEY	CREEK CT	. OWINGS	MILLS,	MD 211	17
Baltimore,	Pages 1 ment of He ant: If iter ury or oth		20a. Method of Disposition  1	emoval from State R	OOSEVEL	Taton (Name of Paragraphic Par	RK 09/	19/2004	TREVOS		
Balt	permit. Page Department i Important: it any injury o		21. Signature of traperal Septica License	6	8	2. Name and Addi 900 REIS	ess of Facility S TERSTOWN	OL LEVINS ROAD - F	PIKESVI	ROS., I	NC. 21208
}	Physician /Medical		23a. Part1. Enter the disease, or complic shock, of heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	1. /	yclosen		ring, such as card	iac or respiratory a	rrest,	10	opproximate interval Between onset and Death
L	Examiner	-	Sequentially list conditions, if any, leading to immediate	•							
	outed Id ansit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence or).						
8760,	icate be executed physician and s the burial-transit	i Ex	resulting in death) Last	Due to (or as a cons	equence of):						
687	ticate to physics the t	edica	d.								
P.O. Box	that the death certitic led by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown	c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	су			Date of delivery Month D	ay Year
	es Ded		Part II. Dther significant conditions cont  Breat (Aucer T		esulting in the u	nderlying cause g		23e. Did to	\ \ /	ntribute to the	cause of death?
COL	w requir been si should	ietec	Osternenio Arthri	hyroid C		, 8/1		24a. Was			y findings available
of Vital Records,		Completed by	orisipat az,					autor perfo		prior to comp death?	letion of cause of
Zit?	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatier	30 004 0	thos	eath (Check only o		wher (Carrie)	
n of	ing Phys Atter this uneral di	on: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Inje	ury at ork?	Home 5 Resid			
Division	or Attend Iter death irector: , n by the t	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str		]Yes 2 □No	28f. Location (S City or Tox	Street and Nun vn, State)	nber or Rural F	Route Number,
Y	Hospital 24 hours a Funeral C	State Registrar   September									ed. ne cause(s)
-	ro the within 2 ro the comple										y, Year)
	/	P. Bredousheete, MD RES-000 September								ber 15,	2004
	Ъ	60	30. Name and address of person who cor	npleted cause of death (I	tem 23a) (Type,	Print) Sinai	Hospitel	of B	Beltice	esre,	
	Sta Registr	_	31. Date filed (Month, Day, Year) SEP 2 2 2004	Registrar's Sig	ineture (	We .					

			1 - State of Maryland / Department of Health and Maryland / Certificate of Death		giene Reg. No. 1) () ()	29987
	Physicia	an	1. Decedent's Name (First, Middle, Last)  RON   SPICKNALL	2. Date of Dea Month	Day Year	3. Time of Death 9:5 P. M.
>	/Medic Examin	al er	4a. Facility Name (If not institution, give street and number)  NORTH ARUNDEL HOSPITAL GLEN BURNIE	MD.	4c. County of Death	RUN DEL
	Funeral Director		5. Social Security Number 220-60-1465 6. Sex 1 M 20+ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	9. Birthy y, Year) 9. Birthy Cour Mar	place (State or Foreign otry) yland
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	-	1	0d. Inside City Limits
	e Mary le-feh liffed	ctor	Maryland Anne Arundel Glen Burnie			1 ☐ Yes 2X No
	with th a or 28	Funeral Director	10e. Street and Number 10f. Zip Code 21060		10g. Citizen of What Could	itry?
	death ms 23	nera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f fleatili and Menial Hygiene. item 27 is marked other then "natural; or items 23a or 28e-f ehow other treumatic event, Ite Medical Examinar must be notified at		1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☑ No  If Yes, Give Year or Dates:	rican, etc.)	Black, White, Specify: Whi	
21215-0036	n 72 ho "natur edical	Completed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b. Kind of Business/In	dustry
212	d within giene. or then "	omo	Elementary/Secondary (0-12)  College (1-4or 5+)  5+ years  Site Supervisor		Honeywell	
	be filed ital Hygis od other	Be			Maiden Sumame)	
Maryland	should be and Mental I is marked o	ို	Ronald Gostomski Glo:  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run.	ria Palm al Route Numbe		Code) .
	1 and 2 s Health ar tem 27 is				a, Maryland	
Baltimore,	Pages 1 ar nent of Hea int: If item:		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20c. Location - City or To	
Iţi.		1		/2004	Baltimore,	
Ba	permit. Departr Importe eny inji	1 12	4001 Ritchie Highwa		eral Service timore, Mary	
	Pnysician		23a. Fant 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a		rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		Chamic Order his			1090.
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):	,		10 475
9	nificate ng phy as the	ed	IF FEMALE:			
.O. Box	that the death certificated by the attending placed for use as to	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 Note of pregnancy 1		23d. Date of delive Month	ery Day Year
<b>a</b>	quires that in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to the	ne cause of death?
Records,	The ate h	Completed		24a. Was a autop perfor 1 Yes	prior to co death?	psy findings available mpletion of cause of 2 No
Vital	Phyeicien: The I this certificate ha ral director, page	Be	25. Was case referred to medical examiner?  1 Types to Type   Hospital: 1 Types tight 27 FR/Outpatient 27 FR		-	
of	# = E	J: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (Specification of the following occurred to the followin	y)
Division	Attending Part death.  ector: After by the funer	Certification:	2 Accident investigation M 1 Yes 2 No	28f. Location (S City or Tow	Street and Number or Rura	I Route Number,
Ö	itel or urs afte rel Dir					
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, o	date and place, and due to	the cause(s)
	To	Σ	29b. Signature and title of certifier  D - 5 2 2 0 3		29d. Date signed (Month,	
	1)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PRATIBHA SHARMA 3001 S. HANDUER STK	LEET,	SUITE 203	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 2 2 2004			21225

Please	Type or	<b>Print in</b>	Black	indelible ink.	Ensure	All	Copies	Are	Legible.
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			For State	State of Mar		artment of F		, ,	2001	29988		
			Registrar  1. Decedent's Name (First, Middle, Las	st)	00	rincate or	Dealit	2. Date of Death	No.	3. Time of Death		
	Physicia /Medic			ORRIS		SMILOVIT	Z	Month September	19 2004	12:40 AM		
5	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Death			
			Sinai Haspit		imore	Baltir		ty		N/A		
	Funeral Director		5. Social Security Number 6. S 201–22–4717	ex TM 2□F 7.Age (	(In yrs. last birthday, 98 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month Day, 1 JAN . 14, 1	.906 9. Birth	place (State or Foreign ntry) PA		
	p >		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	neation				10d. Inside City Limits		
	shov	5			BALT				1 V Yes 2 □ No			
	the N	Director	MD 10e. Street and Number	N/A	DALT	10f. Zip Code		. Citizen of What Cou				
	3a or	io	5914 BLAND AVENU	E		77	21215			USA		
	death	Funeral	11. Marital Status	12, Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp.	ecify Yes or No-	14. Race - Ameri Black, White,			
9	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Menlard Hygiene, I feel them 21s or 28e-f show ten 27 is marked other than "neturel; or items 23e or 28e-f show other treumetic event, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:	ritodii, etc.)	Specify:	WHITE		
200	s hour		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business/In	dustry		
ב ה	hin 72 Pan "ne Medili	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most of work d)			·		
7	ad wit	Con	9		OWNE	R			TRUCKING			
alla	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		CMTL	OVITZ	18. Mother's Name ESTHER	e (First, Middle, Ma	•	JMAN		
2	houid d Mer narke natic	2	AARON  19a. Informant's Name/Relationship (	Type Print)					City or Town, State, Zip			
Š	tre is		MELVYN SMILOWIT						MD 21215	3 0 0 0 0 0		
<u>5</u>	of Health Item 27 other tra		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place		Date 20	c. Location - City or To	own, State		
altimor	Pages nent of ent: If ury or		1 X Burial 2 □ Cremation 3 X 1		MT. SHAR	ON CEMETE	RY 9/19	10.000	RINGFIELD			
Sall	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other 2005.		21. Signature of Funeral Service Licen	1500					N & BROS. KESVILLE,			
	<u>0</u> 0 = 6 0		23a. Part1. Enter the disease, or com	- from						Approximate		
			shock, or heart failure. List only	one cause on each line		ter the mode of dyir	ig, such as cardiac	or respiratory arrest	,	Interval Between Onset and Death		
) <del>I</del>	nysician /Medical	i i	disease or condition resulting in death)		nonia					2 weeks		
B	Examiner			D00 10 (01 23 2	consequence ory.							
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):							
	ecute and -trans	Examine	that initiated events resulting in death) Last	C. Due to for as a	consequence of):							
8/00,	certificate be executed oding physicien and use as the burial-transit				consequence or,							
200	ficate p phys is the	edicai		_ d								
XOD	n certi anding use a	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		☐Ectopic pregnancy	,		23d. Date of deliv	'		
_	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the past 12 months?	4 Pregnant at ti		Other (specify)			Month	Day Year		
٦ ک	d by the	Phy	9 Unknown  Part II. Other significant conditions of		not resulting in the	inderlying cause an	on in Part I	23e Did tohar	cco use contribute to t	he cause of death?		
ds,	requires that the een signed by th hould be detache	d by				art Fail	ure,	1 ☐ Yes	1.4	pably 4 Unknown		
Hecords	law requas been 2 shoul	ompleted	Atrial Fibrilla	tion, Der		, , ,		24a. Was an	24b. Were auto	ppsy findings available		
	9 4 9	omp	All toll Tib.	1000	101101			autopsy performe 1 Yes 2	d? prior to co death? No 1 ☐ Yes	mpletion of cause of 200 No		
	ilcien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)	2.0			
01 <	S D	To	1 ☐ Yes 2 No	Hospital: 1 Impatient	2 ER/Outpatie		4   Nursing no	me 5 Residenc	ce 6 ☐Other (Specia	(y)		
	ding Phys The After this funeral di	ion:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (	Wor		28d. Describe how	injury occurred	1 1-		
DIVISION	eath or:	icat	2 Accident investigation 3 Suicide 6 Could not b	e Diese of Injur	y - At home, farm, st		Yes 2 □No	28f. Location (Stree	et and Number or Rura	al Route-Number		
2	or Attendated after death	Certification:	4 Homicide determined	building, etc.	(Specify)	ioot, ractory, orneo		City or Town, S	State)	and the same		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral											
	the H hin 24 the F nplete	Medical	one)	and manner state	ed.	29c. Licens						
,	vitl Con	-	29b. Signature and title of certifier	eman I	20	290. Licens		290	Date signed (Month,			
	1		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	Print)	000	Se	UTURDER 19	1,2004		
	り		Eileen Zingma	m D.O.	24011	Nest Belv	edere B	altimore	MD 212	15		
	Sta		31. Date filed (Month, Day, Year)	. Registrar	's Signature	uts)						
	Registr	rar	SEP 2 2 200	4 Blows	N. M.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death ecedent's Name (First, Middle, Last) 21, 2004 Day **Physician** omas peptember /Medical 4b. City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and pumber Examiner Baltimore jare Randallstown 8. Date of Birth Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 M 2 M F 220-05-8509 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene the state of the state 1 ☐ Yes 2 ☐ No Kandal MD Saltimore Director 10g. Citizen of What Country? 10e. Street and Number Ka 5412 Completed by Funeral . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 12 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Black Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary Secondary (0-12) College (1-4or 5+) Benutician 8. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event 20ce. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) DR. Apt. 231 Ranchiktaun, mo Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Randallstown, Mb King Nemorial 21. Signatur Funeral Service Lice 22. Name and Address of Facility Gary P. March Fly 270 Fredhilton Pass Balto, mo 21229 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, of heart failu Immediate Cause (Final disease or condition resulting in death) OBSTRUCTIVE PULMONARY Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner physician and the burial-transit The taw requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 4 Hunknown 2 🗆 No 3 Probably should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 ☐ Yes 2 No Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Paursing Home 5 Residence 6 Other (Specify) 2 2 NO 1 Inpatient 2 ER/Outpatient 3□ DOA 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 5 Pending 1 Tes 2 🗆 No investigation death. 2 Accident Diractor: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 C Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after the Hospital or within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

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31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

30. Name and address of person

led Mil

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

18

Car

DHMH 17 Rev 1/2001

29c. License number

4049

Meade Rd. Lintaium MD 21096

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** SEPTEMBER 20, 2004 2:35A John Frank Tarleton /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center Saint Joseph Medical Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**X**M 2□F Days Hours Yrs. **Director** 03/28/1940 214-36-7617 64 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 7 ia marked othar than "natural", or items 23a or 28a-f show traumatic evant, the Madical Examiner must be notililed at 1 ☐ Yes 2X No Director MD Baltimore Kingsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21087 11534 Cedar Lane U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Xes 2 ☐ No Vietnam If Yes, Give Year or Dates: Fra 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify þ 3 ☐ Widowed 4 ☐ Divorced White Era Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Vice President of Operation 12 Harbor Cruises 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental Joseph Theodore Tarleton Catherine Isabel\_Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rtment of Health 11534 Cedar Lane - Kingsville, Maryland Doris R. Tarleton (wife) 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if any injury or once. 109/23/2004 Perry Hall, Maryland Donation 5 Other (Specify) Camo Chapel U.M. Ch.CEm. 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licens, É assidni 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBRAL HEMORRHAGE FEW HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CARDIAC ARREST 24 HOURS Sequentially list conditions, Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed ORTHORY ARTHRY DIFFERE resulting in death) Last Due to (or as a consequence of): burial-t nding physician use as the burial Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Š signed b 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ELECTROLYTE ABNORMALITIES Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page 2.2 No 1 Yes 22 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attanding 5 Pending investigation 1 Natural after death. Diractor: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner speed. 29a. Certifier cal (Check only one) Medi To the 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature 35453 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+

Registrar DHMH 17 Rev 1/2001

State

INDA BARR

31. Date filed (Month, Day, Year)

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SEP 2 2 2004

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

TOWSON MARYLAND 21204

76 21 OS ER 32. Registrar's Signature

			1 - State Registrar	State of Mary	•	artment of rtificate of			F1 /7 /7	22	20001
			Negistrar     Nededent's Name (First, Middle, Last)			Timeate of	Death	2. Date of Deat	eg. No.	-	3. Time of Death
N.	Physici		H	Beatrice Tho	mpson			Septembe	er 21,	Year 2004	3:35 A. <sup>M</sup>
7	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	Беросная	4c. County		3.33 A.
			Millennium Healt	h - Marley		Glen	Burnie		Anne	Aru	ndel
	Funeral		Social Security Number     6. Security Number	. 37	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,			ace (State or Foreign try)
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	pur *		Usual Residence of Decedent  10a, State 10b, County	100	. City, Town or Lo	neation				11	Od. Inside City Limits
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	with a or	Funeral Director	7575 E. Howard F	oad.		10f. Zip Code	060		0g. Citizen of W		ry r
	leath	era		12. Was Decedent Ever	in U.S. 13			ecrfy Yes or No-		· America	an Indian
10	r Iter	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No			Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)		, White, e	
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Ž	should the should the	10	19a. Informant's Name/Relationship (Tv	_	105 14-16	- Add (C	et and Number or Run				
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical	Check only 21 Medical Exemis	ner: On the basis of exam	knowledge, deat	occurred at the t	ime, date and place,	and due to the car	use(s) and man	ner as sta	ted.
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	Ö	al or s afte al Dire	Certification:	4   Homicide		- Dull	ding, etc. (Spec	iry)					City or To	wn, State)		
		To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only	Certifying	Physician: To the	ne best of my kn	owledge, dea	th occurred	at the tim	ne, date a pinion, de	nd place, ath occur	and due to the	cause(s) an	id manner as s	tated.
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylan	•	artment of I			giene, 0 0 4	29993
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Stanley Wilford		n Jr.					04 12:50 a M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of I	Death	4c. County of Dea	
		Ķ.	Manor Care of Beth  5. Social Security Number 6. Sex		last hirthday)	Bethe If Under 1 Year		Hrs. 8 Date of Birth	Montgon	
2	Funeral Director		578-58-1591	M 2□F 59	* -	Months Days		Min. 8. Date of Birth (Month, Day 6/6/194	(Year) C	thplace (State or Foreign ountry) Shington DC
			Usual Residence of Decedent					0/0/1/1	, wa	
	how		10a. State 10b. County	_	ty, Town or Lo					10d. Inside City Limits
	e Ma Sa-f	cto	Maryland Montgome	гу ве	thesda					1 XYes 2 No
	ith th	Dire	10e. Street and Number 5721 Grosvenor La			10f. Zip Code	01/		10g. Citizen of What C USA	ountry?
	s 23s	Funeral Director		ane 12. Was Decedent Ever in U	C 12		814	2 (Specify Ves or No-		erican Indian
	ter de Item	Ë	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	.5.	If Yes, specify Cut	oan, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	Black, Whi	
99	urs at	þ	3 ☐ Widowed ♣ ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>₹</b> ☐ No	Specity:		Specify:	Black
21215-0036	within 72 hours after death with the Maryland one. Than "natural", or items 23e or 28e-f show he M. Jical Ex., nither , ust be nutified a	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most o	of working	16b. Kind of Business	/Industry
2	ithin nan "	npie	Elementary/Secondary (0-12)	College (1-4or 5+)			ed)			
2	led w lygier her th	CO	12 17. Father's Name (First, Middle, Last)		_Draft	sman	18 Mother's	s Name (First, Middle,	Governmen	t
Maryland	ntal Hed of	Be c	Stanley Wilford Was	shington Sr			01a		obtainable	
2	hould id Me mark matic	우	19a. Informant's Name/Relationship (Ty)	0	19b. Maili	ng Address (Stree		or Rural Route Numbe		
<b>⊠</b>	ith an 27 is rtrau		Lydia Washington/Da			•		Dr. Upper	-	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Hygiene 23 is marked other than "natural" or temperate and injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event, the Modified at any injury or other traumatic event event.		20a. Method of Disposition	20b. F		osition (Name of matory or other pla		Date	20c. Location - City or	
Ë	Page ient o nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  3 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		coln Ceme		9/21/2004	Brentwood,	MD
alti	permit. Departm Importa any inju		21. Signature of Fundral Service License	ee //	2	2. Name and Addr	ess of Facility	aral Homo		
0	88 1 8 8		Men E	Welle.	3	401 Blad	ensburg	Road Bren	itwood, Mar	yland 20722
44 48			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat ne cause on each line.	th. Do not en	ter the mode of dy	ing, such as ca	ardiac or respiratory arr	rest,	Approximate Interval Between Onset and Death
16.	Physician		Immediate Cause (Final disease or condition	Aspiration	Pneumo	nia				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		- 4.1				
1	Examine:	7.	Sequentially list conditions, if any, leading to immediate	Ischemic Ca		opatny				
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	200 (0) (0) (0) (0)	(40/100 01).					
	e be executed sicien and e burial-transit	Exar	that initiated events cresulting in death) Last	Due to (or as a conseq	quence of):					
760,	icate be executed physicien and s the burial-transit	cail	ι,	J						
89	tificat ng phy as th									
Вох	eath certific attending pl	an/h	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		□Ectopic pregnanc	су		23d. Date of de Month	livery Day Year
	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of d 9□Unknown	death 5[	Other (specify)			WORL	Day 1 Bai
P.0	d by 1	Phy	Part II. Other significant conditions cor	atributing to death but not res	sulting in the u	inderlying cause o	ven in Part I	23e. Did to	bacco use contribute t	o the cause of death?
ds,	signed be det		, and a significant contained con	g to down but how	, and a					robably 4 🖾 Unknown
Vital Records,	w requir been si should	Completed						24a. Was a	24h Were a	utopsy findings available
Rec	has has ge 2 :	ш						autop:	sy prior to	completion of cause of
a			25. Was case referred to medical				OC Blace o	1 Pes		3 2□ No
5	Physician: this certific ral director,	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	hor	f Death (Check only or ing Home 5 ☐ Resid		acifu)
on of	Jing After fune	-	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju	etc.	28d. Describe h	ow injury occurred	, and the second
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At his building, etc. (Specific	ome, farm, st	reet, factory, office		28f. Location (S City or Tow	itreet and Number or R n, State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C	29a. Certifier Control 2 Service Examination one)	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, deat ation and/or in	th occurred at the the threating the street in the street	time, date and popinion, death	place, and due to the coccurred at the time, of	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier		N. 2		se number		29d. Date signed (Mon	th, Day, Year)
•			Alpanal	jurani	וז נש.	0-	2766		9/10/0	54
	!		30. Name and address of person who a A. Goswami M.D.				Suite G	100, Rockv	ille, MD 2	0852
3.	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 2 2004	32. Registrar's Signa	ature	pach				

CPM 04-05921 Amend item 15,9,105,107,111,12,15,165,17-16,19a-5,20a-c,22,per rH, 836,10/5/04 TT

State of Maryland / Department of Health and Mental Hygiene Joseph Williams 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Joseph Williams September 13, 2004 14:41 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1100 Bolton Street Apartment 406 Baltimore 1 Year If Under 24 Hrs. Days Hours Min. 8. Date of Birth (Month, Day, Year May 21, 19 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days 1⊠M 2□F unk 77 Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State Itam 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic evant, the Madical Examiner must be notified at 1 √ Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 **21201** 1100 Bolton Street #406 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk Black, White, etc. 2 should be filed within 72 hours after on and Mental Hyglene. Is marked other than "natural", or Itar 1 ☐ Never Married 2 ☐ Married Yes 2 No unk 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1947–66 1 ☐ Yes 2X No Specify: Specify: black. þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) 12 unk unk U.S. Army 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk Be unkEdward Williams, Sr. Elenora Brooks 9a. Informant's Name/Relationship (Type, Print) Step9.C.M.E. Keisha Davis/ daughter
9.C.M.E. Keisha Davis/ daughter 19a. Informant's Name/Relationship (Type, Print) Step-Pages 1 and 2 nent of Health a ant: If Itam 27 is 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State ŏ Department of Important: If any Injury or once. 4 Donation 5 MOther (Specify) in state Metro Crematory, Inc. 10/01/04 Baltimore, MD 21. Signallus of Euneral Servi 22. Name and Address of Facility Cremation Society of MD, Inc. 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <del>21201</del> 299 Frederick Road Baltimore Interval Between Onset and Death Immediate Cause (Final Pnysician Hypertensive Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 XNo Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other:  $_4$   $\square$  Nursing Home 5  $\square$  Residence 6  $\nearrow$  Other (Specify) SCI-NE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XXYes 2□No 2 this 27. Manner of Death 28d. Describe how injury occurred Certification; 1 XNatural

Hospital or Attending Physician: after death. Diractor: Af filled in by 24 hours a Funaral I

28c. Injury at Work? 28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E. September 14, 2004

30. Name and address of person who completed cause of death (Item 23s) (Type, Print)

and manner stated.

NO 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

SEP 2 2 2004

5 Pending

2 Accident 3 Suicide

4 - Homicide

(Check only one)

29a, Certifier

Medical

State Registrar

investigation

6 ☐ Could not be



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within 2 To the To the

			1 - For State Registrar	State of Ma	aryland / De	partmer e <i>rtificat</i>					giene Reg. No. 1) (		29995
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	/Medic Examir		4a. Facility Name (If not institution, g	ive street and number)		Ba	Hin	Location	2	1	4c. County		
	Funeral Director		219-76-3635	Sex 7. Ag	je (In yrs. last birthd 46 Yrs	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May 14,	1958	9. Birthi	place (State or Foreign ntry) unk
	show	or.	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City, Town o	Location							10d. Inside City Limits
	with the Marylan tor 28a-f show	Direct	10e. Street and Number 22 Athol Avenu	I.P.	Da	10f. Zip	Code	1229			10g. Citizen of	What Cou	Λ
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other then "neturel", or Items 23a or 28a-f show simportant: If item 27 Is marked other then "neturel", or Items 23a or 28a-f show ship injury or other traumatic event, it at Modical Examinational page.	by Funeral Director	11. Marital Status Unik 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S. No unk	3. Was Dece If Yes, spe	dent of Hi cify Cuba		gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14. Rac Blac		
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			30. Name and address of person wh  AMATUM M	MARE	M 501	De, Print)	lph	in s	stre	3 3 et, B	alto M	10)	21217
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or 28	Director	10e. Street and N	umber			10f. Zip Code			10g. Citizen	of What Cou	intry?
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State of Manuard / Department of Health and Mantal Hariana

D		•	State of Maryland / Department of Health and 1- State AMEND ITEM #5,7,8,9,12,17,18,649#64#################################		27 27 27 28 2 2 2 2 2 2 2 2 2 2 2 2 2 2	29997
		Ø.	Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Albert Windsor	AUGUST	$25^{\text{Day}}, 2004^{\text{par}}$	5:40P. <sup>™</sup>
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deal BALTIMORE	th	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 1997 6. Sex 1 Months 2 F 7. Age (In yrs. last birthday) 1 If Under 1 Year   If Under 24 Hr Months Days Hours Mir	8. Date of Birt (Month, Day Sept 1	y, Year)	rthplace (State or Foreign country) unk
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f ehow if it itst be notified at	to	MD Baltimore			1 Yes 2 □ No
	or 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	23a c		3438 Ravenwood Avenue 21213		USA	
36	urs after des nl', or ttams	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puell Yes, Give Vear or Dates:  14. Was Decedent Ever in U.S. Amed Forces?  15. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puell Yes, Give Vear or Dates)	Specify Yes or No- rto Rican, etc.)	19070000	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 1 I Health and 1 I wantkad other than "natural", or itams 23a or 28a-f ehow itam traumatic evant, I'm McJical Erianth at Install Le notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired)	orking unk	16b. Kind of Business	s/Industry unk
d 2	e filed within al Hygiene. i other than 'vant, the me		unk unk  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	ame (First, Middle,	Maiden Sumame)	Z = 1
an	id be kad o ic eve	To Be		E. BRIDG	ETT	<del>'unk</del>
Mary	nd 2 should be f th and Mental I 27 is markad of traumatic eva	ļe-	19a informant's Name/Relationship (Type, Print) MICHAEL DUANE WINDSOR/son P.O. BOX #1010 CAN 111 Penn Street Balt.	ON CITY.C	r. City or Town, State.	Zip Code) 215–1010
Baltimore,	Pages 1 and 2 nent of Health a int: if itam 27 inty or other tre		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify) in State	Date	20c. Location - City o	Town, State
Balti	permit. Pages Department of I Important: If its any injury or of		21. Signature of Euneral Service Licensee Ronald S. Wade Director State Anatomy Boar Baltimore, MD 212	d 655 W.	Baltimore	Street
	Physician /Medical		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	1	est, Islase	Approximate Interval Between Onset and Death
38760,	be executed ician and purial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
O. Box 6	Physician: The law requires that the death certificate this certificate has been signed by the attending physial director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)		23d. Date of de Month	olivery Day Year
rds, P.O.	v requires that t been signed by should be detar	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	o the cause of death?
Vital Records,	The law re cate has bee page 2 sho	Completed		24a. Was a autop: perfor 1 Yes	sy prior to	utopsy findings available completion of cause of s 2 2 No
Vita	ysician: Th is certificate director, pag	Be	examiner?	ath (Check only or		
Division of	Attanding Physic death.  actor: After this to by the funeral dir	ation: To	1 X Yes 2 No 1 I Inpatient 2 ER/Outpatient 3 DOA 4 Nursing  27. Manner of Death 1 Accident S Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No		ence 6 (Spether (Spetow injury occurred)	ecify) SCENE
Divisi	i git o	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or A n, State)	ural Route Number,
	tha Hospital nin 24 hours a tha Funeral I npletely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Examiner: On the basis of examination and the place 2 Medical Exa	e, and due to the curred at the time, d	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To tha within 2. To tha complet	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mon.	th, Day, Year)
			O.C.M.E.	Al	UGUST 26,20	004
		6	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street,	Baltimor	e, Marylan	d 21201
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 2 2004  Message Francisco Signature			

		1	For State Registrar	State of I	Maryland		artment rtificate			ınd M		giene	) [,	29998
	Physici		Decedent's Name (First, Middle, JAY)		DORF		WEINS				2. Date of Dea		, <sup>v</sup> 200	3. Time of Death 14 1:38 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 12802 SAGAMORE FOREST LANE				4b. City, To	own, or l	ocation o	TOWN		4c. Count	ty of Death	
	Funeral Director		212-62-7824	. Sex 7.	Age (In yrs. las		If Under 1 Months	Year Days	Hours	Min.	8. Date of Birth	, 1954	9. Birth	nplace (State or Foreign untry) MD
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County  MD BAL	ΓΙΜΟRE	10c. City,	Town or Lo	cation STERS	TOWN	l					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28	ai Dire	10e. Street and Number 12802 SAGAMORE	FOREST LA	NE		10f. Zip C		1136			10g. Citizen of	What Co	untry? USA
920	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Eracinal matter collified at	by Funeral Director	11. Marital Status 1  □ Never Married 2 🛣 Married 3  □ Widowed 4  □ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ∭XNo		Was Decede f Yes, specif 1 🗌 Yes 2		panic Oric , Mexican Specify:	gin? (Spe , Puerto l	city Yes or No- Rican, etc.)	14. Ra Bla Speci	ack, White	rican Indian, n, etc. WHITE
21215-0036	2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", ' aumatic event, I'm Medicul Exa	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4)	or 5+)	(Give life. l	dent's Usual kind of work DO NOT use RATE G	done du retired)	iring most			DAHNE		
Maryland	ould be file Mental Hy arked othe	To Be C	17. Father's Name (First, Middle, La	A .	[	OORF			RH0	NA	(First, Middle,			POLLACK
	12 mg	!	JAY M. WEINSTEIN	,		12802		MORE		EST	LANE -		RST0W	IN, MD 21136
Baltimore	8°5 = 5		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Spe	cify)	ate cen	netery, crer AREI	natory or oth [FILOH	e <i>r pl</i> ace, CEM	1. 9	/19/	2004	WOODL	AWN,	MD
Bal	permit. Pa Departmer Important any injury		21. Signature of Funeral Service Lic	Tun		89	900 RE	ISTE	RST0	WN R		IKESVI		MD 21208 Approximate
No. of Concession, Name of Street, or other Persons, Name of Street, or ot	Physician /Medical Examiner		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Due to (or	as a conseque	STO N	YA 1							Interval Between Onset and Death
,0928	ate be executed obysician and the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a conseque									-
P.O. Box 68	death certific e attending p id for use as	Completed by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		n 2 ∏ Fetal d t at time of dea	leath 3	Ectopic pred Other (spec						ate of deli	very Day Year
	50 00	ed by Pl	Part II. Other significant condition:	s contributing to deat	h but not result	ing in the u	nderlying cau	ısə givər	n in Part J.		23e. Did to		atribute to	the cause of death?
Division of Vital Records,	The law ate has b page 2 s	Complete									24a. Was a autop perfor 1 Yes	SV	Were aut prior to c death? 1 \( \text{Yes}	topsy findings available ompletion of cause of
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 Inp.	atient 2 EF	R/Outpatien	nt 3 DQA		26. Place  4 □ Nu		ne 5 Resid	ne) ence 6 □Ot	her (Spec	nfy)
ision o	fter	Certification:	27. Manper of Death  1 Natural 5 Pending 2 Accident investigal 3 Suicide 6 Could no	tion the Geo Bloom of	njury 2 Day Year) 2 Injury - At hom	8b. Time of Injury	М		at ? es 2 □ I	No	28d. Describe h			ral Route Number,
Div	ital or A irs after ral Direc led in by	Certif	4 Homicide determine	building,	etc. (Specify)						City or Tow			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examination stated.	n and/or in	vestigation, is		nion, dea		ed at the time, o		, and due	to the cause(s)
	$\sim$	4	7,000	Choud				D4	14	06		Sep	+ 18	3 <sup>th</sup> 2004
	18		30. Name and address of person who suite 20.5 Pl						Sm.	eet	- Ba	404 204	cre	•
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 2	2004 32. R	strar's Signatu	J.	bed	/						

			For State Registrar	State of Mar	-	artment o				giene Reg. Na.	2001.	29999
			1. Decedent's Name (First, Middle, Las	")					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Lott	ie Winger	ter				9	20	04	6.19pm
100	Examin		4a. Facility Name (If not institution, give	street and number)	0 1 1	4b. City, To	wn, or Locatio	n of Death		4c.	County of Dea	th
			Heritage Ho	reow	Kenas	2700	S. Hau	0.114	napole			rundel
	Funeral		5. Social Security Number 6. Se 324-09-8077	M 20 7. Age (	In yrs. last birthday 1 Yrs.	Months D	ays Hours	Min.	8. Date of Bir (Month, Da	v, Year)	Co	thplace (State or Foreign
	Director		Usual Residence of Decedent	9	T			I	FEB 21,	191	.5  111.	inois
	/land		10a. State 10b. County	1	0c. City, Town or I	ocation						10d. Inside City Limits
	Mary Fig.	to	Maryland Anne Aru	ınde1		Anna	polis					1 ☐ Yes 2 X No
	r 28s	lrec	10e. Street and Number			10f. Zip Co				10g. Citi	zen of What Co	ountry?
	23a C	Funeral Director	3101 Drogue Co	ourt		21	403				USA	
	dea	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13	. Was Decedeni If Yes, specify	t of Hispanic ( Cuban, Mexic	Origin? (Spec can, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit	
36	or it	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 🔀					Specify: Wh	ite
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. I marked other then "natural", or itams 23s or 28s-f ehow imaric event, the Modical Examination and the modified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	16a Daa	adopte Herral C	\anation				nd of Business	
15	n 72	Completed	(Specify only highest grad	le completed)	(Giv	edent's Usual C e kind of work o DO NOT use n	done durina m	ost of workin	g	TOD. KI	na or basiness	moustry
7	withi ene. then	duc	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		itress				R	estaur	ant
9	Hygin Hygin bither with a sent.	Ö	17. Father's Name (First, Middle, Last)					ther's Name	(First, Middle,	Maiden	Sumame)	
lan	lid be ked ic ev	To Be	George Rak				Ju	lia S	zezu1	ko		
Maryland			19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address (S	treet and Num	ber or Rural	Route Number	er, City o	r Town, State, a	Zip Code)
	and 2 salth a n 27 io		Carolyn Duffy/1			1 Drog		urt A	nnapo	lis	, MD 2	1403
re	of He of He litem		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Romaval from State	20b. Place of Disp cemetery, cri	oosition (Name of	of r place)	Da	ate	20c. Lo	cation - City or	Town, State
Ĕ	Pages nent of I ant: If its ury or o		`4 □ Donation 5 □ Other (Specify	)	Metro Cr	ematory	, Inc.	9/21	./04	Ва	1timor	e, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	500/	2	Cremet	Ton S	Öciet	y of	MD,	Inc.	
_	825 2 3			regorchik		299 Fr	ederi	ck Ro	oad Ba	Lti	more,	
J.			23a. Part1. Enter the disease or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.	e death. Do not er	nter the mode of	f dying, such a	as cardiac or	respiratory a	rest,		Approximate Intervat Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a C //	A		_					Orisot and Boath
100	/Medical Examiner		resulting in death)	Due to for as a	onsequence of):	410						
	LAdimine		Sequentially list conditions, if any, leading to immediate	b. Due to for as a	MENT	19						
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):	alia						
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (br as a c	consequence of):	0/1						
8760,	be e sician buria			,								
687	icate phys s the	Physician/Medical		d								
Вох	certii nding use a	J/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		- ·				2	23d. Date of del	ivery
ă	d for	ciai	in the past 12 months?	1□Live birth 2↓ 4□Pregnant at tin		□Ectopic pregr □ Other (specif					Month	Day Year
o.	t the c	hys	9 Unknown	9 Unknown					1			
٠ <u>٠</u>	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but i	not resulting in the	underlying caus	se given in Par	rt 1.	23e. Did to	obacco u	se contribute to	the cause of death?
Records,	w require been sig should b	edk	Derres	5/01					101	es 2	No 3□Pr	obably 4 Unknown
00	aw re s bee	Completed							24a. Was autop		24b. Were au	stopsy findings available completion of cause of
	The lavate has	E				-			perfo	rmed! 2 No	death?	2 No
Vital		Вес	25. Was case referred to medicat				26. Pla	ce of Death	(Check only o	ne)		
	Attending Physician: r death. sctor: After this certific by the funeral director,	To	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA	Other: 4	Nursing Hom	e 5 🗆 Resid	lence 6	Other (Spec	cify)
n of	ng Ph fter th meral		27. Namer of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury		Injury at Work?		8d. Describe h	ow injury	occurred	
Division	tendi eath. or: A	Certification:	Accident investigation  3 Suicide 6 Could not be			М	1 Yes 2					
Ë	or Att	III.	4 Homicide determined	28e. Place of Injury building, etc. (		treet, factory, of	ffice	2	8f. Location (S City or Tox	itreet and m. State)	d Number or Au )	ıral Route Number,
			20a Codiliar	velolen T- 45 - 5 - 7	my knowledge - d	th agenced and	ha time date	and class	and due to the	2011	and	atatad
	Hospital 24 hours a Funeral I	edicai	29a. Certifier Certifying Phy (Check only 2 Medical Exam	rsician: To the best of r iner: On the basis of ex and manner state	amination and/or i	nvestigation, in	my opinion, d	eath occurre	d at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	2/1/		29c. Li	cense numbe	r		29d. Date	signed (Monti	h, Day, Year)
	⊬ 3 <del>⊬</del> 8		· la	chastla	To Mail	)	30058	16 8	3		9/2	12/1
	10		30. Name and address of person who o	ompleted cause of dear	th (Item 23a) (Type	Print)	1000	0 0			114	104
	· ·		RICHARD Ata	TO(M.D.	344: W.	41/11.	BCUD.	5417	re 32	6,5,	WERS	Part, NO ZUE
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's	Signature		/					//
	Registr	ar	SEP 2 2 2004	File and	/h //as	all!						

DMAS E. WE	IR.	ICH For State Registrar		Marylan	d / Depa	artmen		th and M	lental Hy			30000
Physici /Medic Examin	cal	Decedent's Name (First, Middle, La     Thomas Edward     Aa. Facility Name (If not institution, giv     UNIVERSITY HOSP	l Weiri	.ch nber)			Town, or Local LTIMORI		2. Date of De Month SEPT	Day	Year 2004 County of Death	3. Time of Death
Funeral Director		5. Social Security Number 6. S 270-38-4639 Usual Residence of Decedent	ex ▼M 2□F	7. Age (In yrs. I 61	ast birthday) Yrs.	If Under Months		nder 24 Hrs.	8. Date of Bir (Month, Da Dec 2	th y, Year)	Cou	place (State or Foreig http)
he Maryland 88a-1 show olilied et	ector	10a. State 10b. County  Maryland Baltimor	e		, Town or Lo kton							10d. Inside City Limit
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 Is marked other than "natural" or items 23a or 28a-f show traumatic avent. The Medical Evantural to notified a	Funeral Director	10e. Street and Number  2212 Corbett Ro 11. Marital Status  1 Never Married 2 Married					L11 ent of Hispanio fly Cuban, Me	Origin? (Spe kican, Puerto F	cify Yes or No Rican, etc.)	USA	Race - Americ Black, White,	can Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours aft filth and Martal Hygiens Z 1 is marked other than "natural; or r traumatic avent, the Wedicul Evant	Completed by	3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)	Year or Da	ites:	16a. Deced	l  Yes 2 lent's Usual kind of word OO NOT us	l Occupation		ng		pecify: Wh: I of Business/In	ite <sub>dustry</sub>
land 21; uld be filed wit tental Hygiene rked other tha tic avent.	To Be Corr	17. Father's Name (First, Middle, Last)  Edward Weirich	5+	40.01)		Coach		other's Name	(First, Middle,		ege Basl umame)	ketball
re, Mar 1 and 2 sh Health and tem 27 Is m		19a. Informant's Name/Relationship (1948)  Megan Luker, Daug  20a. Method of Disposition	hter			Pensh	urst W	mberorRura ay Vir	Route Numbe	each,	Own, State, Zip VA 234 Ition - City or To	456
Baltimore, permit. Pages 1 at Department of Hea Importent: If item any injury or othe once.		1 Burial 2 To Cremation 3 C 4 Donation 5 Other (Specify 21: Signature of Europa) Service Licer Dawn F. McDonal	e C	erate	ro Cre	mator	y Tnc.	2774	Ė		ore, M	eryland nd 21228
Physician /Medical Examiner		23a. Part1. Enter the disease, or comy shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that ca	or as a consequ	alti	or the mode	of dying, such	as cardiac or	Baltim respiratory ar	rest,	Marylar	Approximate Interval Between Onset and Death
760, te be executed ysician and ne burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	or as a consequ								
Box 68760, eath certificate be ex attending physician for use as the burial for use as the burial.	Physician/Medical	in the past 12 months?		ome of pregnar th 2 Petal	death 3	Ectopic pre Other (spe				230	d. Date of delive	nry Day Year
P.O.	by	1 Yes 2 No 9 Unknown  Part II. Other significent conditions or	9□ Unknov	wn				art I.	23e. Did to	10		e cause of death?
	Completed								24a. Was a autop:	an 2	24b. Were autop prior to con death?	osy findings available appletion of cause of
	ion: To Be	25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of (M) nth	Injury Der Year)	R/Outpatient 28b. Time of Injury	28	Other: 4 Cc. Injury at Work?	Nursing Hom	C ec only or e 5 ☐ Resid	ence 6	Other (Specify	)   T- &
S partie	Certification:	Accident investigation  Graph of the content of the	28e. I lace o building	Injury - At hor g, etc. (Specify)	STRE	TI		2	Bf. Location (S City or Town	State)	fumber or Rural	Boute Number,
To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only 2 Medicel Exam 29b. Signature and title of certifier	/sicien: To the biner: On the bas and manne	sis of examination	rledge, death on and/or inve	estigation, i	the time, date n my opinion, o	death occurred	d at the time, d	ate and pla	d manner as sta ace, and due to igned (Month, L	the cause(s)
V			M) completed cause			rint)	o.c.m.i		re, Mar		T. 20,	2004
Sta Registra DHMH 17 Rev 1/20	ar	31. Date filed (Month, Day, Year) SEP 2 2 200	47	gistrar's Signatu	ıre							

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